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The Protruding Ear and Its Surgical Treatment

A. Clifford Abbott, F.R.C.S. (Ed.), F.R.C.S. (Can.)

Department of Surgery, University of Manitoba, Winnipeg

Any child born with a deformity begins life handicapped. This is particularly true of facial deformities. In our present stage of medical science, it is recognized that a hare lip and cleft palate are best repaired at an early date. It aids nutrition of the child and allows the partially malformed structure to develop in their normal position. Normal development of speech also depends on early repair. There is also a psychological side to this question. The child as it grows up learns to appreciate that he or she is different from other children, and resents the fact. As a result, his childish outlook is warped and different from other children's. The mental anguish of the parents is, in the majority of cases, grossly underestimated.

Protruding ears have long been neglected. They are allowed to grow and flourish and bring ridicule and stigma to the young or older owner without relief. Children frequently develop an inferiority complex as a result and avoid their playmates. Others compensate for their deformity by the development of a super-abundance of self-expression, which in turn makes them unpopular with their playmates. This in turn is a constant worry to their parents. I do not have to remind you how apt children are in detecting anything unusual or abnormal in their playmates. Tact is an unusual trait in a child and as a result they invariably jeer at, deride and attach a very descriptive nickname to this unfortunate playmate with the protruding ears. One of my little patients had the very descriptive name of "Dumbo" firmly attached, much to the distress of his mother.

For this reason, it is wise to repair these protruding ears before school age. Many childish heartaches are thus avoided, and many unpleasant defensive reactions remain unlearned as a result. Moreover one cannot forget the mental anguish of the parents, great or small as it may be, of these small children. Their relief in many cases is astonishing and must be experienced to appreciate.

Adults seek medical aid for various reasons. Some are definitely conscious of their deformity and endeavour to hide it. Repair of the deformity gives them a new outlook on life. The other group suffer from no psychological effect. They have this defect repaired for practical reasons. Some are unable to gain employment owing to their unusual appearance. Others find it difficult to wear a headgear in some branches of industry. Women have difficulty wearing the latest fashion in hats.

Embryology

The external ear or pinna is formed in the sixth week of intrauterine life from six tubercles. (Fig. 1A.) Two arise from the dorsal end of the posterior edge of the mandibular arch. A third appears in association with these, slightly above and posterior and may be said to be the third tubercle lying in front of the first cleft. The remaining three develop from the anterior edge of the second or hyoid arch posterior to the first cleft.

Towards the end of the second month, the ear begins to take form. From the most ventral tubercle of the first arch is developed the tragus of the fully formed pinna; from the middle tubercle of the second arch the antitragus; the middle and upper tubercles of the first arch unite with the ridge of the second arch to form the helix; the dorsal tubercle of the second arch forms the antihelix; the most ventral tubercle of the same arch, the lobule. Most mammals have pointed ears, but in man the condition is transitory; its position, however, is indicated in the adult p i n n a by the rudimentary "Darwin's tubercle."

Towards the end of the second month, the ear begins to take shape. It is still pointed. The crura of the antihelix are unformed and the ear protrudes from the side.

About the sixth month the helix becomes well formed. (Fig. 1B.) The tubercles forming the antihelix and its two crura develop. If this takes place a normal ear is formed, the ear being supported by the cartilaginous ridges at an angle of about thirty degrees from the head. (Fig. 2.)

Abnormally prominent ears are usually congenital. Heredity has undoubtedly some influence. They are usually bilateral but may be unilateral. In some cases both ears are unusually prominent and quite unequal.

Some claim they may be acquired by bad habits such as a child constantly sleeping with its head on one side with the ear curled forward. Badly fitting caps may also produce some deformity.

Types

Abnormally prominent ears may fall into two general groups.

1. The ear is normally formed but is attached in an abnormal fashion. These ears may appear large in their original position but appear quite normal in size when placed at the normal angle in relation to the head. They are seldom smaller than normal.

2. The ear is malformed. The commonest type found is that due to a non- or mal-formation of the antihelix and its crura. The ear has no support and falls forward. The concha may be normal.

The second commonest deformity is that due to over growth of the cavum conchal. The helix, antihelix and crura may be normal. The result is the so-called "cat" ear.

3. A great number of the protruding ears that one sees is due to a combination of the first two. Naturally there are a great number of variations.

Surgical Treatment

The surgical treatment of this type of deformity dates back to the 19th century. Each decade has added some improvement in treatment. No set surgical technique can be described as each case is an individual architectural problem.

In cases in which the helix and antihelix are normally formed, the deformity being caused by an overgrowth of the cavum concha, excision of an elliptical portion of the concha posteriorly with careful reconstruction of the antihelix and its crus is sufficient. One must, in all cases, break the cartilaginous spring which holds the ear to the side, if one wishes or hopes to keep the ear in normal position.

Where the cartilage has remained unfolded, the antihelix and its crura being absent or poorly formed, a more complicated procedure is necessary. Here the cartilage may have to be incised in elliptical fashion, the incised edges being everted so as to form an antihelix together with an anterior and posterior crura. In these cases it is most important to divide the spring formed by the antihelix so that the ear when sutured will remain at the proper angle, which is thirty degrees.

In some cases the lobule tends to remain prominent, following replacement of the ear at its proper angle. Here again the cartilaginous support must be divided so as to allow all portions of the ear to fall into the proper plane.

One must warn against too wide removal of skin from the posterior aspect of the ear. Otherwise the normal sulcus will be obliterated and be unsightly when viewed from behind.

Anaesthesia

Many recommend a local anaesthesia. Some of the cases we have encountered required an anaesthetic to have the sutures removed. It would have been quite impossible to do the plastic repair under local anaesthetic. We have used ether in all cases.

Sutures

Baxter recommends steel sutures, the advantage being minimal reaction in tissue. Limited experience with wire sutures in areas where subcutaneous tissue is scanty has been unfavorable, as they can be palpated and are a constant irritation to a patient who is inclined to be neurotic. Some claim they are actually painful. Up to the present time we have used catgut for the soft tissues and cartilage and fine silk for the skin.

It has been recommended that both sides be done at one time. Average time spent on our cases is approximately one hour per ear. We have made it a rule of doing one side at a time, and to do the worst ear first.

Dressings

At the termination of the operation, a moist mold made from cotton wool is placed behind the ear, the edges protruding well beyond the margins of the ear. If this is molded when wet it forms a firm mold when dry. The interior of the ear is also packed by moist cotton wool and we have found that this forms an excellent firm mold until sutures are removed. After the ear is carefully packed, a pad of cotton wool is placed over the ear and over this a piece of sea sponge or rubber sponge. This in turn is fastened with elastoplast or adhesive plaster, care being taken to apply only the proper pressure. We have found that a snugly fitting operating room cap reinforced by elastoplast, is an excellent overall dressing.

The dressings are removed on the seventh to the tenth day — all sutures are removed. Some surgeons recommend that the ear be left uncovered at this time except being bandaged to the side of the head at night. We have preferred to keep the ears bandaged to the side for approximately three weeks. At this time, all wounds are perfectly healed, but even after this time it is well to wear a night cap for the first two or three months.

Summary

1. No maneuvers practiced by anxious mothers restore congenitally malformed ears into normal shape and position.

2. Removal of skin only is quite useless. Some form of plastic repair on the cartilage must be done.

3. The spring in the cartilage must be broken and in some cases, in more than one place.

4. On occasion, two or more pieces of cartilage must be excised. No set operation, as a result, can be described.

5. Care must be taken to replace the ears symmetrically. This is one advantage of doing both ears at the same session.

6. Avoid plastering the ear too close to the head.

7. If the ear is abnormally large, it can be reduced by some suitable maneuver.

8. It is not unusual to have a prominent fold of skin on the back of the ear at the end of this operation. This will flatten out in practically all cases.

9. The best time for repair is around four or five years of age.

10. We feel that replacement of prominent ears is a very justifiable and worth while measure. The appearance of the patient is greatly improved, the mental aspect entirely changed, and the patient and parents are exceedingly relieved and grateful.

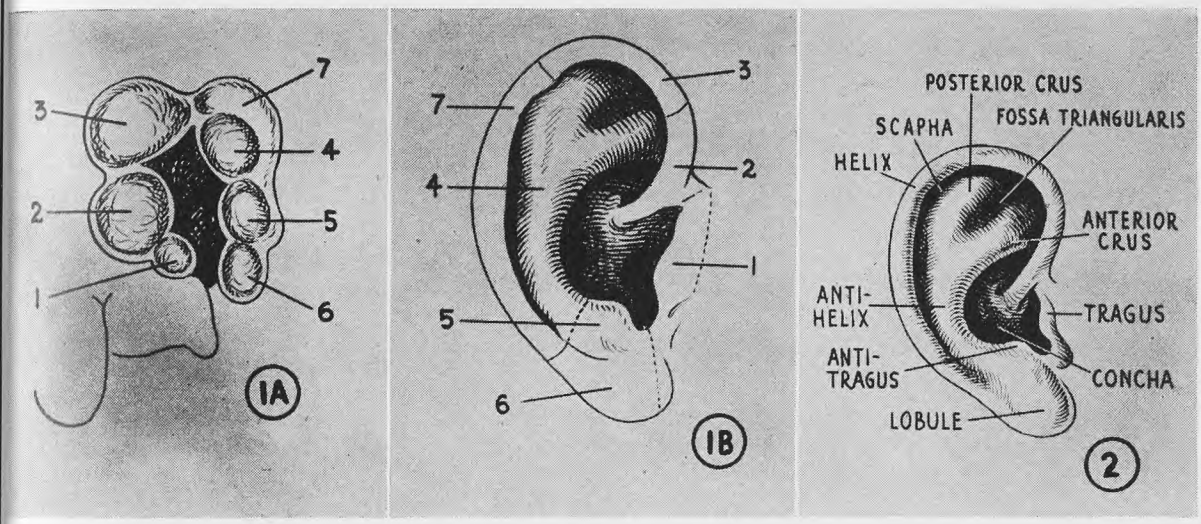


Figure 1A and 1B

Schematic drawing illustrating the embryology of the ear. Tubercles 1, 2, and 3 arise from the first mandibular arch. Corresponding numbers in A and B denote the same structure. 1. Tragus. 2. Crus of helix. 3. Helix Tubercles 4, 5, and 6 arise from the hyoid arch and form 4. Antihelix. 5. Antitragus. 6. Lobule. 7. A skin elevation behind the tubercles of the hyoid, which forms the descending portion of the helix or posterior margin of the ear. **Figure 2**—The normal ear.

Figure 3

(a-b-c-d) (3 months old) — (a) So-called "cat ear" with tremendous overgrowth of the concha and underdevelopment of the antihelix. (Mother refused to wait for repair until child was older.) (b) Side view showing marked cupping and huge cavum. (c) Front view, 2 weeks later. (d) Side view showing minor loss of helix at upper end, which will be repaired later.

Figure 4

Malformation of antihelix: (a) Antero-posterior view showing protrusion of ears, the left more than the right. (b) Posterior view. (c and d) Lateral views. (e and f) 10 days following repair. The top of the left ear is slightly undercorrected. (g) Lateral view of right ear, showing the good effect of reconstruction of the anti-helix. (The baby face shown in a-b-c-d is quite changed but is the same child.)

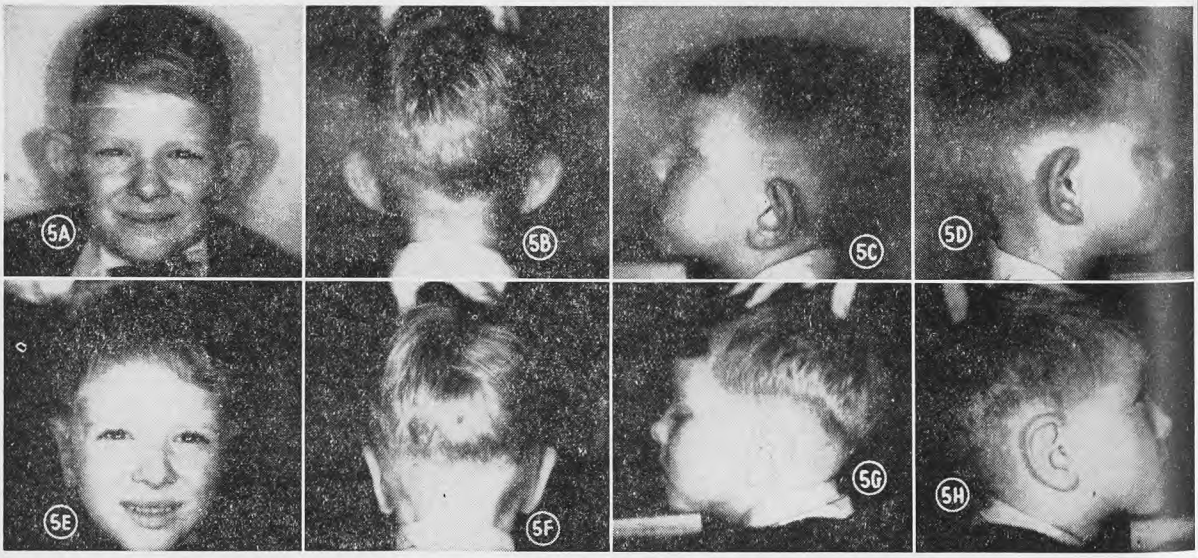


Figure 5

Moderate protrusion of ears due to badly formed antihelix. The ears were soft, flexible, and fell forward easily due to lack of cartilaginous support. (a-b-c-d) Before operation. (e-f-g-h) Two weeks following operation.

Figure 6

Overgrowth of the concha and lateral protrusion of the lobule. (a-b) Before operation. (c-d) One month following operation. The lateral protrusion of the lobule has not been entirely corrected due to failure in completely breaking the cartilaginous spring.

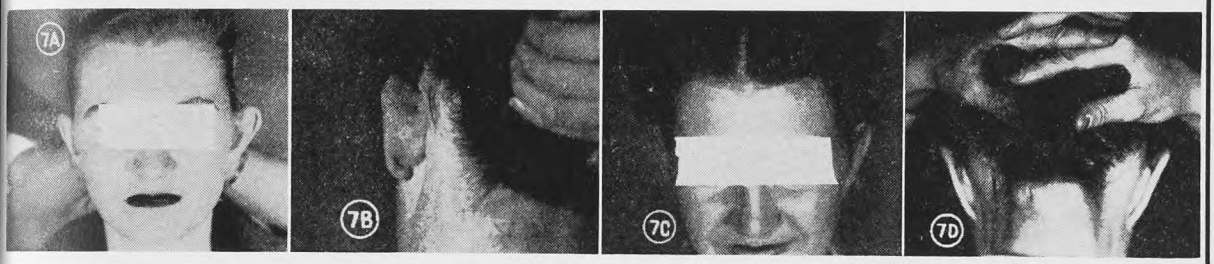


Figure 7

Unilateral protrusion due to overgrowth of concha. The antihelix was essentially normal. Note folding in of lobule (7b) in contra-distinction to No. 6 and its complete correction (7d).

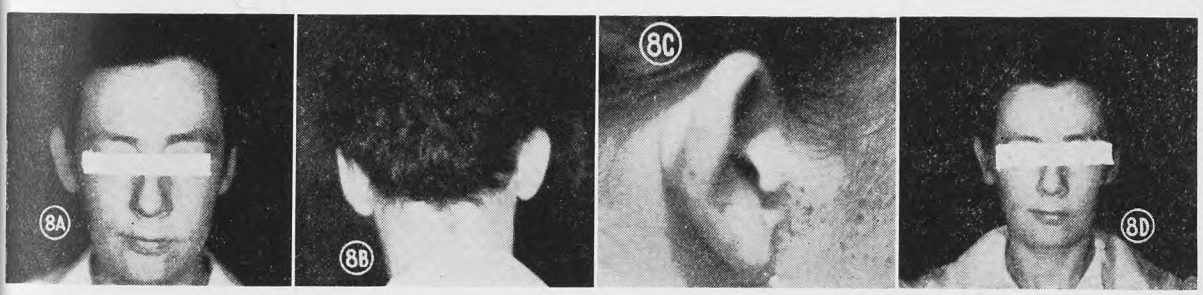
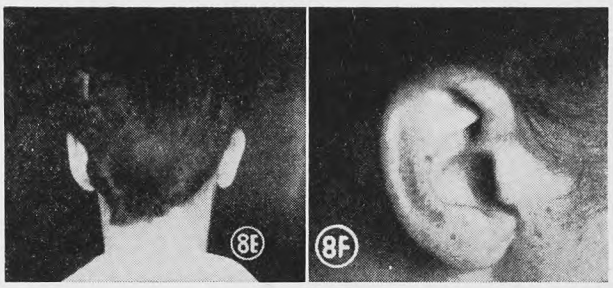


Figure 8

Unilateral protrusion of ear due to overgrowth of concha. (8b) illustrates how deformity is more noticeable from posterior view. Note in (8c) that the posterior edge of helix points abnormally laterally and that it hides the interior of the posterior half of the ear. (d-e-f) Postoperative appearance three weeks later. (f) Shows a perfectly normal lateral view.



The Abbott Clinic, Winnipeg. Photographs by Wm. Doern, Winnipeg General Hospital.

Medical Critique

The Third and Last of a Series by John McEachern, M.D., F.A.C.P., F.R.C.P. (Can.)

III. On Angina Pectoris

No apology is needed for the discussion of this subject. For one thing, this is the physicians' favorite personal malady. For another, it is man's most important cause of death after 50.

We all know that the underlying cause is arteriosclerosis of the coronary arteries. This sclerosis may not give rise to symptoms if an adequate collateral circulation has developed. Of eighty-six consecutive cases studied at autopsy at the Mayo Clinic, 40% had no symptoms of coronary disease.

On the other hand, if the collateral circulation is inadequate, symptoms of coronary insufficiency appear. Such symptoms may be periodic or progressive, leading to occlusion, thrombosis or death.

If, however, the rate of occlusion is slow and treatment adequate, the obstruction may be bypassed and clinical recovery occur. This means usually a two to five year program.

The following syndromes may be grouped under the heading of coronary insufficiency:

1. The syndrome of angina pectoris.

2. The symptoms associated with cardiovascular syphilis when the coronary ostia are involved.

3. Cases of progressive dyspnoea due to coronary disease.

4. Congestive heart failure from the same cause.

5. Disorders of the heart beat such as heart block or auricular fibrillation associated with coronary sclerosis.

6. Coronary thrombosis with cardiac infarction which may precede or terminate the above syndromes.

Only two of these conditions commonly give rise to pain, namely, 1 and 6. In fact one may say that the **only** important cause of heart pain is that due to coronary disease.

There is no such thing as pseudo angina, for a man either has it or he has not. The first and best description of angina was written by Sir William Heberden, 1710-1801.

Here is Seneca's graphic account as related by Sir William Osler: "The attack is very short and like a storm. It is over in a moment. No other bodily danger appears more grievous. Why not? Because to have any other malady is only to be sick. To have this is to be dying!"

Here is how some patients have described this pain:

"A hand of iron grasping the heart."
"A band of metal compressing it."
"Compression of the breast bone."
"Insufferable oppression in the chest."
"Gas squeezing the heart."
"Once experienced one is always waiting for the next attack; often one has not long to wait."

The pain, tightness or sense of constriction in these cases always begins in the substernal region. It may radiate from there to one or both arms, the neck, the jaw, the back of the neck or even a tooth. Pain down the arm alone is not diagnostic of coronary disease.

As a rule the same amount of effort will always produce the same discomfort, which is quickly relieved by rest. The reaction time may be reduced and the pain increased by a full stomach or by facing a cold wind (a warm muffler around the face and chest is helpful). These people become experienced window shoppers, as the attacks are momentary if the patient stands still.

The patient often perspires during the attack and belches at its end. This frequently gives relief, and the attacks may be attributed to indigestion. In 2% of cases the pain may be in the epigastrium leading to further confusion.

Angina due to coronary insufficiency is rare in women, common in men, the peak age being 57 years, but it may occur at almost any age. It is extremely rare in women without hypertension. In men hypertension may or may not be associated.

Apart from a moderate hypertension, there may be little to find on physical examination. The heart may be normal in size with no murmurs. The electrocardiogram may be quite normal (70%).

The diagnosis is chiefly made by the history. In doubtful cases, I have found the Harvard step test of value. After measured exercise, transient changes in the electrocardiogram may occur, confirming one's suspicions.

Others use a mixture of 10% oxygen and 90% nitrogen to produce anoxemia and changes in the electrocardiogram. There is no change in normal subjects.

Psychosomatic disturbances are common in coronary disease. Before the onset patients are often tense, nervous, worried, high strung—intelligent, high pressure types.

After the onset of the disease these people are frequently irritable, easily upset by unpleasant experiences. They suffer from fear, fear of sudden death, fear of total disability, insecurity, intense

annoyance at not being able to exert themselves, fear of being placed in a position where they may have to exert themselves (as in avoiding a street accident). Believe me, all these fears are very real.

As John Hunter said (1728-1793), he had angina for many years: "My life is in the hands of any rascal who chooses to annoy or tease me." This proved to be a prophecy for he died suddenly, following a meeting of the board of St. George's Hospital, London, when he became angered at disparaging remarks made by a colleague. An autopsy showed calcareous arteries.

The mental factors which determine disability in coronary insufficiency have been described by Dr. Sprague:

1. Physical incapacity brought on by the anginal syndrome, congestive failure, etc.

2. The character of the patient's work. The manual laborer must work or die in either case.

3. Fear of death or disability. This fear is often increased by the gloomy prognostications of the physician who is protecting himself against the chance of the sudden death of the patient.

4. The influence of disability insurance.

5. The attitude of industry which as a rule makes the cardiac patient unemployable.

The anginal syndrome is both over and underdiagnosed. It is often underdiagnosed by the patient before he seeks medical attention, as indigestion, gastritis, muscular rheumatism, etc. In fact, it is frequently difficult to persuade these patients that the pain is of cardiac origin.

On the other hand, one sees innumerable patients who have been told that they have angina and who have no such thing at all. Much misery and mental suffering may be avoided if these cases are carefully investigated at the onset. Remember the pain is always substernal in true angina. The farther away from the midline, the less likely is it due to heart disease (Hepburn). Left inframammary pain is never due to coronary disease.

Case M. F., female, age 45, had a severe pain along lower left border of ribs on getting out of bed. This was followed by dull pain over same area (continuous). She was diagnosed as a case of angina pectoris and kept in bed for four months. During this period two normal electrocardiograms were taken. Subsequently an X-ray of the spine revealed an intervertebral disc at the appropriate level. Large doses of Vitamin B Complex relieved the pain.

In the past six months one has seen six cases of cervical disc with pain down the arm which had been diagnosed as cardiac in origin.

Fibrositis of the chest wall is frequently mistaken for cardiac pain by both patient and physician. This pain is exaggerated by movement, deep breathing, coughing. Tender nodules may be felt. Occasionally one is fooled the other way, in a case that really has angina plus a fibrositis.

A man (J. B.), age 45, had been told that he had angina pectoris. He was in the habit of walking to work about 30 minutes after his meals. During this walk he would have pain at the lower end of the sternum. It was found that he also had the pain on Sundays, sitting in a chair. A duodenal ulcer was found.

H. M., a male, age 35, had severe pain in the chest and coughing of sudden onset. An electrocardiogram was taken which showed changes which were thought to suggest coronary disease. Five months later he still had pain plus a severe cardiac neurosis. A routine chest plate revealed a spontaneous pneumothorax.

Herpes Zoster before the appearance of the rash has fooled a good many of us. If severe, the pain may suggest coronary thrombosis. The appearance of the rash creates some mental discomfort if the physician has stuck his neck out.

A cervical rib on the left side may cause confusion.

Acute pericarditis gives rise to severe pain in the chest which might suggest an occlusion. The high fever at the onset and an early friction rub should suggest the diagnosis. Here the pain is usually praecordial rather than substernal. Lesions of the oesophagus sometimes simulate angina.

Last week a patient complained of pain at the lower end of the sternum. She thought it might be heart trouble. A small ulcer was found at the lower end of the oesophagus with associated cardiospasm.

The pain in some cases of hiatus hernia may suggest angina, especially if it occurs on lifting. Cardiac pain rarely occurs with this type of exertion.

Osteoarthritis of the spine with radiculitis may confuse one. Here the pain occurs on movement of the spine, is worse at night on a soft bed.

Gall bladder disease may simulate angina. Conversely both may be associated in the same person. The pre-existing heart disease is made worse by gall bladder disease.

Excellent results occur in these latter cases if the patient is carefully prepared and the gall bladder removed.

"Treatment has been defined as the art or science of amusing a sick man with frivolous speculations about his disorder and of temporizing ingeniously, until nature either kills or cures him." (Stroud.)

Treatment in angina pectoris must be directed toward controlling the patient's whole life and

environment, his psyche and habits, his sleep, food, daily activities and worries.

Never tell a patient that he has angina pectoris. This produces a fear complex which is difficult to eradicate. All it is necessary to say **if you are sure,** is that the pain originates in the heart and that if he follows sound medical rules he will eventually get better.

Reduction of weight is important to those who are obese. Avoidance of gas producing foods is helpful. "Had I not to eat I would not suffer." The most important thing of all is for the patient to keep below his pain level. He should learn to live within the income of his circulation. Eight to twelve hours' sleep a day is a must. He must discard all activities not vital to economic existence.

Dr. Riseman of Harvard University studied the treatment of a large number of cases over a period of ten years. The following table was adapted from his work and fits in with one's own experience:

Drug Therapy of Angina Pectoris

Good:

Nitroglycerine gr. 1/200 H.T. fresh.
Nitroglycerine gr. 1/500 every hour in severe cases.
Theobromine sod. acetate enteric coated gr. 7½, 4 x daily.
Aminophylline gr. 3, 4 x daily.
Phenobarbital, codeine.
Quinidine gr. 3, 4 x daily alone or with aminophylline gr. 1½.

Fair:

Other Xanthopurine drugs
Theophylline
Theominal
Oxygen
Whisky
Analgesic X-ray
Bed rest for six weeks

Of Little Value:

Sodium nitrite gr. 1
Caffeine
Papaverine
Potassium Iodide
Coramine
Depropenex
Tobacco

Injections of Hypertonic saline
Heart hormones
Male sex hormones
Thiourocil
Thiamine
B Complex
Niacin
Digitalis
Kerr abdominal belt

In conclusion, I would like you to believe that coronary insufficiency or even an actual occlusion is not necessarily fatal or completely disabling.

Too many of these patients are condemned to chronic invalidism without reason. There is reason for considerable optimism if these people are properly handled and treated. They are frequently very intelligent patients of great value to their community and we should do everything possible to help them and guide them over the crisis until the collateral circulation takes over the job of nourishing the heart muscle.

Even of this does not occur, "there is a sort of kindly compensation, as in no other disease do we so often see the ideal death—death like birth, "a sleep and a forgetting." — Sir Wm. Osler.

Remarks on Tuberculosis

Presented at a Clinical Session of the Manitoba Medical Association, at St. Boniface Hospital, by Dr. A. C. Sinclair, Medical Director, St. Boniface Sanatorium.

Tuberculosis is perhaps as old as man himself. The antiquity of the disease can be traced back before civilization to the new stone age, and has, therefore, existed for at least ten thousand years. We are apt to think of tuberculosis as a chronic disease which attacks the lungs of humans. This is a dangerous conception, for, of late, doctors in Sanatoria have been startled by the high percentage of acute tuberculosis being admitted. It must be remembered that tuberculosis can be an acute, as well as a chronic disease, that it is capable of attacking any organ of the body, and that it can cause illness at any time of life from infancy to old age.

Being a universal disease, tuberculosis gains access to the bodies of almost 100% of the population before the end of life's span. In the majority it does no harm; in a few it remains quiescent and may be reactivated in old age to be the terminal illness; others not sick themselves become spreaders and pass on the seeds to posterity, thereby insuring its continued existence.

Tuberculosis has undoubtedly caused more suffering and loss of life than all the wars since the world began. Since 1914 Canada participated in two world wars and has lost approximately 100,000 lives. During the same period tuberculosis has caused the death of at least 180,000 Canadians. In the past six war-years Canada's losses due to Axis operations have been around 36,000, which is also the figure for tuberculosis deaths during the same period; that is, 6,000 per year. The death rate from tuberculosis, steadily declining up to 1939, has now levelled off and will probably show an increase in the near future. This calls for a redoubled effort in our campaign to eradicate the disease.

Case Finding

The most potent force in the discovery of tuberculosis cases is still the medical practitioner. His aid must be enlisted to an even greater degree if tuberculosis is eventually to be conquered. The practitioner is apt to feel that he no longer needs to be responsible for case finding due to the number of clinics and surveys which are now in existence — such as routine X-raying of military personnel, industrial workers, schools, etc. While these are to be commended, they cannot replace, but must only supplement the capabilities of the medical man. Surveys usually consisting of routine X-rays of the chest cannot discover the extra-pulmonary lesions. However, they do find disease earlier than by any other method. A well-rounded programme is many-sided and should include tuberculin testing, history, physical examination, X-ray and laboratory findings. The chest specialist requires all these, so they must also be available to the profession at large. The tuberculin test is a valuable aid in anti-tuberculosis programmes, and should be done on every man, woman and child in the community; and because more than one percent of the population turn positive each year it should be repeated at least yearly on negative reactors. Evidence of tuberculosis can be found in about 12% of newly positive reactors, and of these one will eventually have active pulmonary tuberculosis. The value of tuberculin testing is re-emphasized in the following quotation taken from "Tuberculosis Abstracts," October, 1945:

"The tuberculin test, on which much of the early work in tuberculosis was based, came into serious question when significant numbers of tuberculin negative reactors were found to have pulmonary calcification suggestive of tuberculous infection. The evidence now accumulating indicates that calcification is a non-specific response of lung tissue to invasion, and may be called forth not only by the tubercle bacillus but by histoplasma capsulatum, coccidioides immitis, and perhaps other organisms. Tuberculin testing, therefore, takes again its rightful place as a biological test for the presence of the tubercle bacillus, while chest X-rays complement but do not supplant it as a diagnostic procedure."

The History

The value of a good history cannot be disputed. It has the faculty of focussing one's attention on the most likely site of disease and frequently is responsible for the clue to the diagnosis. In the case of pulmonary tuberculosis six types of onset are possible, and if kept in mind will save much embarrassment. There is:

Pneumonic—Clinically resembling lobar pneumonia.

Pleural—Wet or dry pleurisy.

Haemoptysis—Coughing of blood — first bright, followed by dark blood for three or four days.

Catarrhal—Resembling prolonged and/or frequent colds.

Insidious—Unfortunately considered classical.

Allergic—As in erythema nodosum.

The family physician has a very marked advantage in that he knows the family — the personal history and health record of the family and

individual, how they have reacted to previous illnesses, operations, etc. The family physician remains indispensable.

The physical examination, admittedly not at its best in the diagnosis of lung tuberculosis, is nevertheless essential in differentiating it from other common diseases of the chest such as pneumonia, pulmonary sepsis, bronchiectasis, and such endobronchial disturbances as asthma, bronchitis, foreign bodies and new growths. The physical examination is of negative value in pulmonary tuberculosis as it is rarely positive except in advanced and almost hopeless cases. In bone and joint disease positive clinical evidence may precede X-ray evidence by as much as a year or more.

The X-ray film is undoubtedly the Phthisiologist's greatest aid in diagnosis and treatment. However, a negative X-ray finding does not necessarily preclude an otherwise positive finding. For instance, a single posterior-anterior film of the chest leaves certain so-called "Hidden Areas" untouched. These could easily be the sites of fair-sized lesions. The hidden areas have been estimated at as high as 25% of lung volume. A positive sputum test carries considerable weight even in view of a negative X-ray report. German propaganda distributed to Allied soldiers in Italy took advantage of this point, advising our soldiers how to obtain smegma bacilli to be mixed in samples of sputum, thereby yielding a positive acid-fast test. Further, they added that the medical officer would consider his soldier tuberculous but the X-ray would fail to reveal the lesion. Always remember, "You are better to be sick for a few days than dead for the rest of your life," was their advice.

Laboratory Examination

The discovery of the tubercle bacillus in 1882 led to an enthusiastic search for other organisms and by the year 1896 several other acid-fast bacilli were described, among these being bacilli from dust, grass, butter, smegma, feces, and milk. They are all acid-fast bacilli closely resembling the now famous Koch's bacillus. The former are acid-fast saprophytes resembling the tubercle bacillus but incapable of producing progressive disease even when injected subcutaneously or intramuscularly. They are distinguished from the tubercle bacillus by cultural methods and guinea pig inoculation, the value of which is readily recognized especially where a finding of acid-test bacilli is contrary to the clinical and X-ray evidence. Laboratory examinations and tests should not be abused but are essential to an intelligent handling of an average case. They should include one or more of the following: direct smear, culture for tubercle bacilli, and guinea pig inoculation. Finding of tubercle bacilli is an absolute diagnostic procedure whether the disease is in the lung, bronchial tree, kidney, or other organ. I respectfully urge all cases of pneumonia, diabetes, asthma, chronic bronchitis, and prolonged colds to have frequent laboratory examinations for tubercle bacilli as well as the usual tests. This is a moral responsibility which soon may develop legal proportions.

Differential Diagnosis

In recent years, as if to add spice to life, two new diseases have entered the differential diagnosis of pulmonary tuberculosis. The first, appearing early in the present war with the return of the influenza-producing organism, is "virus" or "atypical" pneumonia. The radiological appearance is typical of tuberculosis. History and clinical evidence do not always allow for differentiation and, as the leucocytes tend to be low, tuberculosis is favoured rather than pneumonia. Tubercle bacilli, of course, are absent. The diagnosis is established by the rapidity of clearing which is not characteristic of tuberculosis. Sulfa drugs and penicillin do not affect Virus Pneumonia.

The other condition which resembles pulmonary tuberculosis is called Transient Focal Pulmonary Edema. It is described in the July, 1945, issue of the "American Review of Tuberculosis." The condition became apparent during large X-ray surveys where positive X-ray findings of a transitory nature with very little associated ill-health were discovered. The authors conclude:

"It is our belief at the present time that these evanescent and variable areas of increased pulmonary density are focal zones of transient pulmonary edema, probably associated with the allergic state; they are a local manifestation of the individual's response to an allergen elsewhere, not an inflammatory nodule nor a more general reaction. It is possible that, if such a state should persist long enough, a pattern suggestive of periarteritis nodosa might be established. Eosinophilia and roentgenographic pulmonary involvement are out of all proportion to the clinical evidence of disease. Under adequate treatment marked improvement is to be expected. Extreme care must be exercised by the phthisiologist, other chest specialists, and the radiologist to ensure that no such cases be stigmatized with the diagnosis of tuberculosis or tuberculosis suspect on one roentgenographic observation. Careful clinical history and physical examination are still required for diagnosis . . ."

B.C.G. Vaccination for Tuberculosis

There is an attenuated living vaccine not unlike that for smallpox, but probably safer. Mass vaccination of infants against tuberculosis has been in vogue in Europe for several years. A vaccine named B.C.G. (Bacillus - Calmette - Guerin) is ad-

ministered to newborn infants usually by mouth. Doubts have been raised as to the safety of this method. On this Continent several centres have been experimenting with this vaccine. Both the Province of Saskatchewan and the Municipal Sanatorium of the City of Chicago, with over ten years' experience with B.C.G., have found it absolutely harmless and of definite benefit in protecting against the disease. Figures from Chicago are as follows:

	T.B. Cases	Deaths
1204 vaccinated children	3	1
1213 controls children	23	4
63 controls newborn	4	3
98 newborn vaccinated	2	0
Total vaccinated	5	1
Total unvaccinated	27	7

Infection by the tubercle bacillus varies in different countries depending on the prevalence of open cases. In Manitoba, slightly under 1% become infected each year as demonstrated by tuberculin surveys. Fortunately the majority never develop the disease, but living tubercle bacilli have entered their bodies, and they are potential cases of tuberculosis. If this group is followed about 12% will develop evidence of infection in one of several ways, the three commonest being:

Pleurisy with effusion.
Erythema nodosum.
Positive X-ray.

In recognition of the above danger it is a significant fact that the Sanatorium Board of Manitoba, acting on the advice of its Medical Advisory Committee, is on record as recommending the use of B.C.G. vaccination for the nursing and other staffs of the various Hospitals and Sanatoria in Manitoba. They have done this in recognition of the added risk being taken by young doctors, nurses, and other personnel around Hospitals and Sanatoria. And, strange as it may seem, the Hospitals are just as dangerous as the Sanatoria because approximately 4% of all admissions to General Hospital are suffering from active tuberculosis but are usually not recognized or discovered until several days or weeks later.

Diabetes, lung abscess, pneumonia, asthma, chronic bronchitis, and the aged patient all deserve your consideration for the ever-lurking tubercle bacillus.

Sanatorium Treatment

A detailed discussion of treatment as practised in Sanatoria is inadvisable at this time, and might even prove dangerous. I wish to bring a few points to your attention. The tendency is toward longer periods of treatment, with a higher ratio of full bed care while in Sanatoria. Home treatment does not prove effective and should be firmly refused. I have, personally, yet to see a satisfactory result, or one that would not have been better in Sanatoria. Home treatment is to be deprecated as it handicaps the medical advisor in the case of multiple lesions. I have in mind a case admitted to St. Boniface Sanatorium wearing a plaster spica for a tuberculous hip. Subsequent events revealed Pott's disease and tuberculosis of the kidney. Another case received home treatment for what was apparently a very light case of pleurisy. A year or two later he required prolonged treatment and spinal fusion for Pott's disease and double psoas abscesses.

A word of warning regarding psoas abscesses. If you were a good student of anatomy you would expect a psoas abscess to point in the femoral triangle. In actual experience this is the exception. The three most common sites in which psoas abscesses accumulate are above Poupart's ligament, the lateral or anterior aspect of the thigh, and in the lumbar region, in the order named. These abscesses being cold are exceptions to the rule and should never be opened. If they are incised by mistake secondary infection enters in a large percentage of cases, and the patient's chances of recovery are seriously lessened. In differential diagnosis and treatment the aspiration needle is used.

Tuberculosis is usually a general disease, and apparently is frequently blood-born. Pleurisy with effusion is frequently followed by disease in other areas, especially the skeleton, the kidneys, and the lungs. Bone and joint disease, in 50% of cases, is found to have an associated active pulmonary lesion and evidence of past pulmonary disease in another 25%. The same figures probably hold for genito-urinary tuberculosis as well.

Something New

The St. Boniface Sanatorium has to admit that its first case of tuberculous endometritis is at present under treatment. A review of the literature reveals surprisingly little, the diagnosis usually being made by accident in cases where curettage specimens are examined for tuberculosis. Discharges collected from the cervix revealed the tubercle bacillus on culture. This patient was examined because of unexplained menstrual disturbance. This disease is much commoner than one would expect. We should all be on the lookout for it.

Chemotherapy

The discovery of the sulfa drugs led to renewed hope for a chemical which would destroy the tubercle bacillus. Extensive literature has accumulated, but as yet no effective compound has been found. In the July, 1945, issue of the "Review of Tuberculosis," two articles on chemotherapy appeared, both with negative conclusions.

Penicillin has also been found to have no effect, but there is one new substance which shows definite promise: Streptomycin is an antibiotic substance developed in the laboratory of Dr. S. A. Waksman and his associates, and first described in January, 1944. A preliminary report on 34 tuberculous patients was given on September 5th, 1945, in the "Proceedings of the Mayo Clinic." The authors report from impressions gained by their study that, "It seems probable that streptomycin has exerted a limited suppressive effect, especially on some of the more unusual types of pulmonary and extra-pulmonary tuberculosis." They go on to say, "It cannot be emphasized too strongly that care in a Sanatorium and collapse therapy are thoroughly proved to be effective therapeutic measures, and that in no instance should these be abandoned in favour of treatment with anti-bacterial agents such as streptomycin, the range of efficacy of which is yet to be conclusively demonstrated." This is, at present, the only known substance which seems to have possibilities. Penicillin and sulfa drugs, however, have found a field of usefulness in the Sanatoria in combating diseases other than tuberculosis, to which tuberculosis patients are also susceptible.

These remarks cannot be concluded without a reference to lobectomy and pneumonectomy for selected cases of pulmonary tuberculosis. Jones, in 1938, reported four cases of lobectomy for tuberculosis. At least one of the operations was performed for a new growth which was later found to be a localized type of tuberculosis. Later, improvements in technique of lobectomy began to develop, especially the change from mass ligation or tourniquet technique to the now more surgical operation of individual ligation of vessels and separate closure of the bronchus. By this new method the incidence of complications such as empyema or surgical emphysema have been lowered along with a smoother post-operative course and mortality rate.

Lobectomy and pneumonectomy for bronchiectasis, malignancy, and selected cases of lung abscess are well established procedures with a low mortality rate, but it was somewhat of a surprise when papers were read in the Chicago, 1944, meetings, presenting a fairly large series of cases in which pulmonary resection was performed for tuberculosis. Maier, of New York, reports lobectomy on sixteen tuberculous patients, fifteen of whom survived the operation, giving a mortality rate of 6¼%. Of the fifteen living patients, twelve or 75% had negative sputum at the time of reporting. Overholt, at Boston, in an excellent article, has reported 63 resections on 61 patients. His operative mortality as given below refers to operations since 1942 when individual ligation was adopted. He reports:

2 deaths in 36: 5.5% of reasonable risks.
3 deaths in 9: 33.3% of desperate risks.
Total: 5 deaths in 45: 11.3% for the series.

This work is still in the experimental stage which is almost always followed by a wave of enthusiasm, often with disastrous results; but in the meantime indications and contra-indications regarding these operations are being collected. One thing appears certain—that pulmonary resection is here to stay, and will eventually find its proper niche as an effective means of combating tuberculosis.

Canadian Physicians' Fine Art and Camera Salon

Change Announced in Entry Regulations

A change has been made in the entry regulations for the Canadian Physicians' Fine Art and Camera Salon. Art pieces up to thirty (30) inches in the longer dimension will now be accepted for judgment in the Salon. This change, the request of a number of interested physicians, has been made possible as a result of the obtaining of the Banff School Auditorium as a place of exhibition; and the Sponsors of the Salon, Frank W. Horner Limited, are pleased to announce that the larger exposition place will permit the showing of larger pictures.

Judges this year for the Salon, to be held at Banff, Alberta, concurrently with the Annual Meeting of the Canadian Medical Association, will be Mr. N. de Grand'Maison, A.R.C.A.; Mr. Carl Rungius, N.A., and Mr. and Mrs. Peter Whyte.

Mr. de Grand'Maison, the well-known portrait artist, is justly famous for his studies of Western Indian types and his pastel portraits of children, while Mr. Rungius, National Academician and winner of the Speyer Memorial, Carnegie and numerous other prizes, has made a specialty of painting American big game.

Mr. Whyte, a native of Banff, Alberta, attended the Otis Art Institute in Los Angeles, California, and the School of the Museum of the Fine Arts in Boston. From this latter school in Boston, Mrs. Whyte is also a graduate.

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Assistant Practitioner Wanted

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Section of Anaesthesiology

P. C. Lund, M.D., Anaesthetist, Deer Lodge Hospital

Abstracts

The Time Factor in Surgical Operations

John Gillies, M.C., M.B., D.A.

Proceedings of the Royal Society of Medicine

Duration-time of surgical operations is frequently a factor which ought not to be disregarded. Just as the aged person, forced to bed by an immobilizing accident, may develop hypostatic congestion of the lungs and anoxia in a few days' time, so the individual lying on an operating table with his respiratory and circulatory functions and metabolism depressed by an inhalational anesthetic or by spinal block analgesia may develop pneumonia but in a much shorter time. Whether he does so or not depends upon a number of factors, including the type and duration of the operation, the anaesthetic agent and its mode of administration, the depth of anaesthesia and the extent to which physiological processes are deranged.

With advances in surgery the time factor is to a certain extent ignored, partly because of the faith which anaesthetists have engendered and fostered in the less toxic agents and newer methods now employed. Under the present abnormal conditions, also, there is growing up a group of younger surgeons in wholetime hospital service who, untrammelled by the rush of competitive surgery, develop what might be called an easy-going tempo. The same might be said of the younger generation of anaesthetists who tend to over-elaborate their part and so extend unnecessarily the time during which the patient is under the anaesthetic.

In the first place, the reference must be made to avoidable delays, particularly the tiresome minutiae which sometimes prolong the interval between the commencement of the anaesthetic and the making of the first incision. For example, in the matter of endotracheal technique, the anaesthetist must ensure that the patient is fully anaesthetized before trying to intubate the trachea. While it is frequently easy to intubate rapidly the patient whose cough reflex still remains active, it is not, for various reasons, the best practice.

Again in the second stage of induction, there is often hesitancy in the management of the anaesthetic. The struggling and breath-holding accompanied by anoxaemia which sometimes occur during a lengthy second stage, may produce deleterious effects such as raised intracranial tension and its sequelae, especially in hypersensitive patients. On this account, recovery from the anaesthetic, let alone the operation, may be considerably prejudiced. Prolonged anoxaemia must be avoided in all cases, chiefly because of the cerebral trauma that may ensue. The relative oxygen lack which may occur in patients with a high oxygen demand, for example in hyperthyroidism and other states where the metabolic rate is raised, is less easily discerned but is all the more serious if allowed to continue for any length of time. Prolonged deep anaesthesia involving saturation of the tissue, with ether for instance, affects adversely the utilization of oxygen by the tissue cells and initiates tissue asphyxia.

Little is contained in the literature concerning the time factor, although most authors take cognizance of it. Langton Hewer (1943) says: "Modern anaesthesia has made possible operations of a severity and duration unthought of thirty years ago. There is a regrettable tendency, however, to prolong operations and thus increase shock. Overdose of anaesthetic, relative or absolute, oxygen deficiency and excessive duration of operation become cumulative after a certain length of time."

Nosworthy (1935) considers that the duration of operation is important in so far as the longer a shock-producing factor is in action, the greater will be the degree of shock produced. He continues: "Whether it is better in the absence of regional anaesthesia to cram a number of shock impulses into a short space of time and finish the operation quickly or to spread the same number of similar impulses over a longer period is questionable." Whilst in intrathoracic and intracranial surgery it may be necessary to allow intervals in order that retraction pressure on vital structures should be intermitted, for most operations under general anaesthesia there can be little doubt that, provided the viscera are handled with reasonable gentleness, there is no call to prolong the time unduly in order to reduce the shock-producing effect of sensory stimulation. The longer the operating time, the greater will be the heat and fluid loss and toxicity from the anaesthetic agent.

Magill (1938) discussing post-operative morbidity, states: "It has been shown that the nature and duration of the operation have as great a bearing on the incidence of post-operative pulmonary complication as the anaesthetic used. The depth of anaesthesia required in the case of an upper abdominal operation subjects the pulmonary bases to a period of inactivity from which only the robust patient can escape unharmed."

To this one might add that the sluggish venous drainage which follows reduced pulmonary activity aggravates the state of sub-oxygenation already present, and so hastens the development of anoxia which, as Chase (1941) has pointed out, is the biggest single hazard to which the surgical patient is exposed. The longer the period of respiratory depression, the greater will be the hazard.

The opinion of the majority of surgeons and anaesthetists would probably hold that the problem is not simply one of the time taken to perform the operation but the period during which the patient is subjected to the influence of depressant drugs.

The premedication, the anaesthetic proper and the post-anaesthetic medication given in the first seventy-two hours, are all concerned together. To follow heavy premedication with prolonged deep general anaesthesia or to allow an anoxic state to supervene during spinal or regional analgesia, can only result in such a degree of post-operative, respiratory and circulatory depression that the patient's life is placed in jeopardy.

The factor of post-medication is important in so far as it effects a prolongation of the deranged physiology produced during operation. The nature of the operation may be significant not only for the abnormal conditions which it creates at the time, but also for the more immediate after-effects on the patient, and the extent to which sedative and analgesic drugs may be required.

The outstanding feature in their series was the high respiratory morbidity (27%) and respiratory mortality (8%) which occurred in the patients anaesthetized with endotracheal gas, oxygen and ether from a semi-closed apparatus (Boyle). This method has two adverse physical factors, (1) the by-passing of the nose which is the natural air-conditioning apparatus of the body, and (2) the low temperature of the anaesthetic vapour.

The nostrils warm and add water vapour to the inhaled air. If the nose is by-passed there is a loss of heat and water vapour with each exhalation and no compensation during inhalation. This causes drying and irritation of the bronchial mucosa with some constriction in calibre of the bronchi and bronchioles.

After investigating the temperatures of various anaesthetic vapours administered by numerous techniques the author found that the "Waters to-and-fro absorption technique" gave the best results in regard to maintenance of temperature and conservation of heat and water vapour. These factors are of paramount importance in prolonged operations especially when other shock-contributing factors are present, such as blood loss and heat loss by radiation from exposed viscera.

The closed absorption technique not only fulfils the requirements of the surgeon, but also helps greatly to mitigate the derangement of respiratory and circulatory function which frequently occurs during long operation and persists in the post-operative period. But even the skillful use of the closed method will not save the patient from the toxic effects of a potent anaesthetic agent distributed throughout the tissues for a long time. If prolonged muscular relaxation is demanded, it should be achieved by nerve block (spinal or regional) whilst the patient is rendered unconscious with nitrous oxide, cyclopropane or pentothal sodium together with a sufficiently high concentration of oxygen to combat anoxia.

It is further pointed out that the anaesthetist's responsibility does not end at the close of the operation as he should take measures to hasten the elimination of the anaesthetic drug and share in the directing of post-medication. Thus the anaesthetist will help still further to modify the time factor by preventing unnecessary prolongation of the effects of the anaesthetic drugs.

P. C. Lund, M.D.

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Neuman, C., et al: The importance of compensating vasoconstriction in unanaesthetized areas in the maintenance of blood pressure during spinal anaesthesia. J. Clin. Investigation. 24: 345-351 (May) 1945.

"It has been necessary to evaluate the effects of various types of anaesthesia upon the peripheral circulation in view of the universal use of anaesthesia in the course of major surgical operations. This report deals with the study of certain peripheral vascular adjustments during spinal and regional anaesthesia."

The pneumoplethysmograph was used to record the rhythmic variation in the fingers and toes dependent upon constriction and dilatation of the small peripheral blood vessels. Such rhythmic pulsations are recorded as pulse waves synchronous with the cardiac beat and alpha waves.

Twenty-eight patients, ranging in age from 30 to 61 years, were subjected to spinal anaesthesia for such surgical procedures as hemorrhoidectomy or herniorrhaphy. The observations reported here were made before the onset of surgical manipulation.

The spinal anaesthetic agents employed were procaine hydrochloride (50 to 100 mgm.) or Monocaine Formate (75 to 150 mgm.).

"In 20 patients who experienced no fall in blood pressure, the expected vasodilatation of the toes occurred, associated with concomitant vaso-

constriction of the fingers which was interpreted as representing a compensating mechanism for the support of the circulation. In four of the eight patients who experienced a fall in blood pressure, vasodilatation of the toes occurred unaccompanied by vasoconstriction of the fingers.

Following administration of ephedrine, vasoconstriction developed in the fingers and the blood pressure rose, while the vasodilatation of the toes continued. In the other four, fall in blood pressure was accompanied by small pulse waves in both toes and fingers, owing, presumably, to decrease in cardiac output. Following administration of ephedrine, the blood pressure rose to or above the initial level, the pulse waves of the toes increased markedly (vasodilatation), while those of the fingers remained small (vasoconstriction). In addition to its other effects, ephedrine acted to restore necessary compensating vasoconstriction to the fingers.

"Because vasoconstriction of the fingers seemed necessary for the maintenance of the initial blood pressure during spinal anaesthesia, it was considered as an index of vasoconstriction in a larger, but not exactly defined, vascular bed of the upper portion of the body. Similarly, the vasodilatation of the toes was considered as an index of vasodilatation in a large vascular bed of the lower portion of the body, on the basis that vasoconstriction of the fingers could hardly be evoked by vasodilatation of the toes alone. The mechanisms for the mediation of the response of compensating vasoconstriction were presumed to be none other than those vasomotor reflexes which are in operation normally for the support of blood pressure. The heightened response in the fingers was attributed to the call for increased vasoconstriction wherever possible in the face of loss of ability of the vascular bed of the lower portion of the body to respond." P. C. Lund, M.D.

Case Report

Elephantiasis, with Special Reference to Non-Parasitic Forms — Dr. W. R. Govan

During the war years, Elephantiasis received considerable prominence in the newspapers and medical journals due to the exposure of vast numbers of American and Australian troops to areas heavily infected with Filariasis. Although we in the temperate zone are not troubled with the tropical parasitic type of Elephantiasis we are commonly called upon to diagnose and treat other forms of the disease.

Elephantiasis is a condition of overgrowth of the skin and subcutaneous tissues in a part subjected to prolonged lymph vascular obstruction. Is occurs most often in the lower extremities and the external genital organs. The swelling is due essentially to obstruction of the lymph vessels and glands in various ways, but as it is often preceded by a condition of solid edema it is generally held that there must be an obstruction of the venous return in the affected part. The oedematous fluid in which the tissues are bathed is rich in protein and stimulates proliferation of fibrous tissue beneath the skin. On account of the stress from within and stagnation of lymph, the skin becomes coarse, thick and corrugated and often discolored. Oftentimes it bears wart-like projections, excoriation and ulcers.

Obstruction of the lymphatic vessels and bacterial infection are the two most important agents to be recognized in causation of Elephantiasis. When such obstruction has been established lymphangitis almost invariably follows.

Experimental Elephantiasis has been produced in dogs by Homans, Drinker and Field, who injected a 2½% solution of Quinine Hydrochloride combined with a suspension of Silica dust into the peripheral lymphatics.

Elephantiasis can be divided arbitrarily into four main groups:

1. Swelling of arm which may develop in carcinoma of the breast.

2. Elephantiasis due to Filarial obstruction.

3. Non-parasitic Elephantiasis—a lymphedema of the leg occurring mostly in young women due apparently to chronic lymphangitis of unknown origin.

4. Milroy's disease, or hereditary edema, also probably lymphatic in origin.

Non-parasitic Elephantiasis such as is our case today occurs as a result of chronic persistent lymphatic obstruction. In addition due to lessened resistance, a recurrent lymphangitis has usually been superimposed on the resultant lymphedema. It involves particularly the legs but may occur in the arms, scrotum, vulva and breasts. There are varying degrees but in well-developed instances the parts are truly elephantine. The skin is enormously thickened and thrown into folds, and the epidermis often presents numerous warty projections. There is a firm edema of the less involved parts. The dermis is greatly thickened and fibrosed and the subcutaneous fat is excessively increased. The deep fascia is surprisingly thickened, its outer surface being rough and papillary, and attached to fibrous trabeculae

separating the edematous fat lobules. Its inner surface is smooth and appears normal, as do the underlying muscles.

The most serious of all causes of lymphatic obstruction is occlusion due to Filaria Bancrofti; the adult form of nematode worm of which the larval form, the Filaria Sanguinis Hominis Nocturia, is found in enormous numbers during the hours of sleep. It is not so much the mere presence of adult worm that does the damage as the lymphangitis with subsequent fibrosis and stricture which are the causal agents.

Treatment

The treatment of Lymphedema depends on the stage in which the disease is encountered. Early mild cases respond to rest, elevation of the part, massage and support by bandaging. In moderately advanced cases the basal metabolism should be determined and if it is low the administration of dessicated thyroid may be of value. Administration of the newer mercurial diuretics may be considered. If the various forms of palliative treatment fail, operative treatment may be undertaken.

There are two main operative procedures for consideration: (1) Lymphangioplasty, introduced by Handley, and (2) the Kondoleon operation described by a Greek surgeon in 1912 which has been popularized in England by Rogers and in America by Sistrunk.

Lymphangioplasty consists of an attempt to furnish a new capillary pathway for the passage of obstructed lymph. This was accomplished by inserting long strands of sterile, tubular woven silk into the subcutaneous tissues from the wrist or ankle to axilla or groin. Silk thus acted as a new lymphatic conduit.

The Kondoleon operation is done by excising an elliptical segment of skin and fascia from the thigh and leg in order to divert the lymph from the superficial lymphatics to the deeper channels of the muscles. An elliptical incision is made from the crest of ilium to external malleolus. The incision is deepened through the subcutaneous fat and areolar tissues, and the segment entirely removed. An ellipse of fascia corresponding to the skin is now removed. Following operation pressure dressings are applied and the leg is elevated for three months. Results have been very encouraging and in many cases the operation has proved of benefit. It removes at least a great part of the unwielding mass. The establishment of secondary connections between the superficial and deep lymphatics is of manifest value.

Case History

Our case for presentation is a Mrs. B., aged sixty, admitted for a radical breast operation because of a scirrhous carcinoma. History and examination revealed a full-blown non-parasitic Elephantiasis of left leg dating its onset back to age seventeen. History revealed that she first noticed a painless swelling of the left ankle and calf. Over a period of many years there occurred an insidious progression of the swelling and enlargement until the whole left lower limb was involved in a lymphedematous process. During these many years she never suffered or complained of any pain or acute attacks referable to the leg. She lived a most active life — married and raised six children. Her main complaint was the awkward weight of the limb. It was not until twenty-five years elapsed — at age of forty-two — that she deemed her symptoms severe enough to warrant operation. At this time she underwent two operations on the leg at the Winnipeg General Hospital. The operative report states that the skin and subcutaneous tissue were excised and the fascia removed from the underlying muscles. The wounds healed well. The clinical result was most satisfactory for several years, but the lymphedematous process began to progress again, and in 1940, at age of fifty-two she underwent a further plastic operation at Rochester, Minnesota. Results were again satisfactory. At the present time she has a large foot exhibiting thick, warty projections. The leg is lean and bare of any subcutaneous tissues. The thigh exhibits a firm edema, with thickened skin thrown into folds.

In conclusion, Elephantiasis is not always a tropical disease — nor is it always filarial. It may be a sequel to any persistent lymphedema and particularly to those complicated by neglect, a dirty skin, and consequent recurrent visitations of reticular lymphangitis. The Kondoleon operation has proved of greater value in certain of these non-filarial forms, and good results are still being reported.

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Manitoba Medical Centre

Dr. P. H. T. Thorlakson

President of the Board of Governors, Manitoba Medical Centre

Western Canada is now enjoying a period of optimism, prosperity and expansion. The normal development of this country has been retarded by a period of depression, drought and war, which extended over a period of 16 years. The complex and difficult situation which faces us today is the result of a combination of three major catastrophies, occurring over a relatively short period of time. The impact of each on our economy has produced at times opposite effects. Each in its own way has been serious, disturbing, and sometimes devastating. In spite of this experience, our Western country is buoyant and prosperous. The people are hopeful, alert, and keenly aware of the opportunities for social and economic betterment. We have no reason to complain about the productivity of our soil; and while the economic returns from our forests, our lakes, and our mines may suffer by comparison with other areas, they are adequate if we protect and develop wisely these sources of natural wealth. The greatest asset of this Western country, however, lies in the spirit of its people, who are prepared to work hard, to overcome obstacles, ignore disappointments, and plan and build for a new day. This combination of human and natural resources gives us good reason to view the future with hope and confidence. However, as practical business men, you should examine critically every new undertaking which calls for the expenditure of large sums of public money.

The Manitoba Medical Centre is a community enterprise, involving many institutions concerned in the problems of health and disease, and the education and training of medical, nursing and technical personnel. It has received the approval of many provincial and city organizations and was incorporated by special Act of the Provincial Legislature on April 7th, 1945. On its Board are representatives of the Council of the City of Winnipeg, the Board of Governors of the University of Manitoba and its Faculty of Medicine, the Union of Manitoba Municipalities, the Minister of Health and Public Welfare of the Province of Manitoba, the Council of the City of St. Boniface, the Children's Hospital, St. Joseph's Hospital, the Sanatorium Board of Manitoba, St. Boniface Hospital, the Cancer Relief and Research Institute, the Winnipeg General Hospital, the Manitoba Medical Association and the Manitoba Hospital Association.

Over the next five to ten years, the member institutions of the Manitoba Medical Centre, one by one, will make their special contributions to this development. The preliminary plans have been laid. Each institution knows approximately wherein lies its particular field of service. Only the Board of Management of the individual institution can determine the time and extent of its new building programme within the Medical Centre. Each institution reserves for itself complete autonomy. Close proximity to one another in the neighborhood of the medical school will provide easy consultation service in both clinical and laboratory investigation; and in time will effect substantial economies in both capital and maintenance costs. A central heating and power plant, a central laundry and service building, and the joint purchase of expensive supplies and equipment would tend to reduce costs. The extent to which these various institutions co-operate and co-ordinate their services will be determined by the management of each, and not by pressure from outside. The Manitoba Medical Centre Board acts as a co-ordinating body, dealing only with those matters which are voluntarily submitted to it by the institutions concerned; it cannot direct or control the activities of the units comprising the Medical Centre. These considerations are fundamental and have been recognized and accepted. They are important for two reasons: First, institutions moving to the area will remain free to decide their own policies; and secondly, by the very nature of this arrangement, there will not be a mammoth campaign for funds to include simultaneously all the various institutions. The public will have an opportunity to examine each appeal on its own particular merits. Progress will be made step by step as circumstances permit and justify. The development will be orderly and gradual and may extend over a period of years. The important consideration is not how fast we can proceed, but rather that we move in the right direction. Never again in our lifetime will there be an opportunity to consolidate the available clinical facilities in order that our University can make the greatest contribution towards the building of a strong, modern teaching and training centre, supporting the work and plans of the Provincial Department of Health. It will make available to medical students, and to physicians and surgeons who return for post-graduate study, the maximum that this community can provide in opportunities for the study of methods of diagnosis and the prevention and treatment of disease. Inasmuch as the Government of this Province is seriously

*Address to Young Men's Section, Board of Trade, Winnipeg, March 11, 1946.

concerned about the maintenance of a high standard of professional care for the people of rural Manitoba, it should give immediate consideration to a plan that will provide improved facilities for undergraduate and post-graduate study.

For many years our hospitals have carried on, rendering a service to the municipalities—including cities—and to the Government itself, at less than the cost of care. In consequence, the hospital that makes the largest contribution towards the care of the poor and provides the major facilities for the training and teaching of doctors, is forced to operate on an annually recurring deficit. This is not only false economy on the part of the Government, but is definitely discriminatory in its effect. Necessary improvements cannot be effected, essential equipment cannot be purchased or replaced, and the staff is of necessity underpaid. This strikes at the very foundation of good medical care, of efficient utilization of diagnostic facilities, and safe hospital practices. Obviously, this must be changed and hospitals be paid for the cost of service. In this connection, it is noteworthy that the Province of Ontario, as from the 1st of January, 1946, has arranged to pay for public ward services on the basis of costs, and that their plans have placed the teaching hospitals associated with medical schools in the highest category.

You will be interested to know what is being done in the other provinces of Canada in the field of hospital finance.

The Province of Nova Scotia is making a money grant for a new building for the Victoria Hospital in Halifax, one of the oldest hospitals in Canada.

The Province of Ontario made a grant of one million dollars toward the cost of construction of a hospital for sick children.

New Brunswick is making a money grant toward hospital construction in the City of Fredericton.

Alberta is giving financial assistance to Calgary General Hospital's new building programme.

It is understood that the Province of Saskatchewan is assisting in new construction for the Regina General Hospital.

British Columbia is making a large money grant to the University of British Columbia for a new medical building, and I believe that it is also making a grant to the Vancouver General Hospital for construction of an addition to the Nurses' Home.

I have mentioned these decisions of the Governments of other provinces in order to make two points: 1. That hospitals cannot make a maximum contribution without adequate compensation for the services they render, and 2, that the Governments of other provinces than Manitoba have recognized the need of giving support to hospitals — especially those contributing to the teaching of medicine.

It is important to state that to date the representatives of the Manitoba Medical Centre have not asked the Government of Manitoba to assume new financial obligations, nor to provide additional hospital beds for the City of Winnipeg. We have, however, asked the Provincial Government to discharge the obligation that it assumed years ago: namely, the provision of adequate clinical and laboratory facilities in the teaching hospitals affiliated with the University of Manitoba. The education and training of medical personnel is definitely a financial responsibility of the individual and the Provincial Government, and not the responsibility of private charitable institutions.

Questions that must be asked about a plan such as the Manitoba Medical Centre are: 1. Does it serve an essential need in the community? In reply to this question, I would point out that present indications are that there is a need for 1,000 additional hospital treatment, and convalescent beds in this community. There are several reasons for this increased demand: The public has become convinced that the safest place to be sick is in a hospital. This is in marked contrast to the attitude of thirty years ago, when patients went to hospitals only as a last resort. One can say that the fear of entering a hospital has been replaced by a feeling of confidence and hope. Statistics of the Obstetrical Service illustrate this trend strikingly: Twenty years ago, eighty percent of maternity cases in this Province were attended in the home; now, over eighty percent are hospitalized.

The second factor which has accelerated this change is the improvement in transportation. Patients are brought in now by car, ambulance, train, and often by airplane. Airplane ambulance will become, I am sure, a common means of conveying patients to hospital centres.

The third factor, undoubtedly, is the Manitoba Hospital Service Association plan, whereby facilities for pre-paid hospitalization are being extended to increasing numbers of citizens of this Province.

The fourth factor is the tremendous strides in medical progress during the last three decades, leading to a realization by the doctor that the simple methods of investigation possible in the home are totally inadequate in the diagnosis and treatment of a seriously ill patient.

It is my conviction that home treatment of disease, with its attendant inconvenience and inefficiency, is definitely a thing of the past. The factors that have operated to segregate sick people in hospitals will continue. Any form of National

Health Insurance will place a terrific load on the already hard pressed hospitals.

A year ago, the Winnipeg General Hospital had a waiting list of 100; now the waiting list is 300. The situation therefore is urgent and may even be termed desperate.

The second question which must be answered about a plan such as the Manitoba Medical Centre: Is it under sound and progressive management? Inasmuch as the success of the plan depends on the organization and co-operation of each individual unit, and the fact that these institutions have on their boards of management efficient and successful business men, we will let the record of service of these institutions to this community and Province speak for itself.

The third question: Will the debt incurred accumulate and increase, or can it be self-liquidating? The answer to this depends on whether the Government and Municipalities of this Province are prepared to pay for hospital service on a basis of cost — and no other arrangement is conceivable. The Provincial Government is already committed to this policy, although it has yet to be put into effect.

The fourth question: Will it make a contribution to this Province from which its citizens can receive improved service and a feeling of security for themselves and their children in times of serious illness, and a sense of pride in the fact that they have contributed towards the establishment of an organization which can provide the highest skill and care of which modern scientific medicine is capable?

The men and women who have worked for over four years on the plans for the Manitoba Medical Centre are convinced that this community enterprise fulfills all these requirements and can stand the closest scrutiny. The invitation to present a progress report to the Young Men's Section of the Board of Trade was, therefore, received and accepted with a feeling of satisfaction. Should your organization at this time be prepared to state publicly your approval and support, and to actually associate yourselves with the work of carrying forward this plan to completion, it would greatly encourage the Board members and stimulate them to work with renewed vigor.

The Manitoba Associated Boards of Trade was one of the first Provincial organizations to give its official endorsation to this plan, and to urge upon the Government of Manitoba the need for immediate action to provide financial support.

I should stress the fact that the project known as the Manitoba Medical Centre in no way conflicts with the proposals submitted to the people of this Province by the Premier, the Honorable Mr. Garson, and by the Minister of Health, the Honorable Mr. Schultz, in January, 1945.

The Government of Manitoba has expressed its determination and outlined its plan to provide for rural areas of this Province improved hospital and diagnostic services. It also proposes the establishment of health units, staffed by specially trained medical personnel whose chief function would be to carry out a programme of immunization against communicable diseases to assist in the detection and isolation of cases of early tuberculosis and venereal disease, and to supervise and enforce sanitary regulations within the area.

Any plan of improved medical care for the people of the Province must be based first on improved facilities for instruction and training of medical, nursing and technical personnel; and secondly, on better organization and more equitable distribution of diagnostic and treatment facilities. The Provincial plan has emphasized the latter and largely ignored the first. It is obvious, therefore, that the development of a hospital and teaching centre in close proximity to our medical school is an integral and essential part of any complete plan for this Province.

In 1944, the Welfare Supervision Board in its report on Hospitals in Manitoba stated: "A modern medical centre, planned as the teaching unit of the University of Manitoba, Faculty of Medicine, and for the instruction and training of other technical personnel in the health field, should be planned for the future, and no further hospital construction in Greater Winnipeg should be authorized until this special study has been made and the future programme mapped out."

The question has recently been asked, "Are we going to have a Medical Centre?" My answer to that is that we already have a medical centre, situated in close proximity to the Manitoba Medical School, which was founded by a small group of doctors over sixty years ago and donated to this University and to our Province in the year 1917. It is the pioneer institution in the field of medical education in Western Canada. Close by the Medical School is the Winnipeg General Hospital, with 600 beds: approximately 200 of these beds are set aside for patients who cannot pay for either hospital, medical or surgical care. Professional care for these patients is a charity service provided by the medical and surgical staff of the hospital. The hospital, through the statutory rates, receives from the municipality concerned about one-half of the cost for the care of these patients.

In this area are the Central Tuberculosis Clinic, operated by the Manitoba Sanatorium Board; the Treatment Unit of the Cancer Relief and Research Institute; the Psychiatric Hospital, and the labor-

atories of the Provincial Department of Health.

The Winnipeg General Hospital is completing plans and making the necessary financial arrangements to erect a 150 bed Maternity Hospital in this area. This unit was one of the first buildings proposed in the original plans of the Medical Centre. It is the considered opinion of specialists in this field that a separate maternity unit is necessary and desirable in the interests of both the mother and the child. The Board of Trustees of the Winnipeg General Hospital has decided to dedicate this new hospital to "The Mothers of Manitoba."

This represents, then, the first tangible evidence that the Manitoba Medical Centre is moving forward; is the beginning. It is the first contribution that the Board of Trustees of the Winnipeg General Hospital is making towards the realization of a plan, which four years ago was only a dream in the minds of a few people. The estimated cost of the building is $750,000.

From the very beginning, the Manitoba Medical Centre has had the encouragement and support of the Mayor and Council of the City of Winnipeg. They are fully cognizant of the fact that this new development will make a real contribution not only to the citizens of Winnipeg, but also to the University of Manitoba as a teaching and training centre, and from there to all the citizens of this Province.

The Winnipeg General Hospital is not asking for a gift from the City; but that the City guarantee a bond issue, to be amortized over a period of years. To date, the Winnipeg General Hospital has met its bonded indebtedness, thanks largely to the generosity of our citizens.

At a later date, when conditions improve and permit, the Winnipeg General Hospital is duty bound to demolish one of its oldest sections, and to replace it by a modern, fireproof building which will accommodate the now scattered teaching services of the hospital. Apart from renovating and general improvements, the General Hospital has no other plans for expansion.

I believe you, as citizens of this Province and as members of a civic-minded organization, are interested in the progress that one hospital has made towards the development of its part in this community project.

The building of a new and modern Children's Hospital, situated on property in close proximity to the new Maternity Unit, will provide additional beds for sick children.

It is anticipated that St. Joseph's Hospital will erect a new building in this area in the near future.

The Board of the Manitoba Medical Centre, and the institutions now included in the Medical Centre area bespeak public support for the plans of these two institutions, and for the other institutions which are a part of the Medical Centre project. Each in its field will play an important part in the establishment of a modern, well-equipped, medical, hospital, teaching and research organization. The Board of the Manitoba Medical Centre now appeals to the Government, and to the people of this Province, for the fullest measure of financial support.

Clinical Luncheon Reports

Pharyngeal Pouch — Dr. A. C. Abbott

A female patient of about forty years of age complained of an uncomfortable feeling in the throat and neck with some difficulty in swallowing. This was followed by a palpable swelling associated with a gurgling sensation and regurgitation of food and water. These symptoms had appeared during the past six months. X-ray examination revealed a pharyngeal pouch about the size of a golf ball, slightly to the left of the mid-line and posterior.

The above symptoms are fairly typical of a pharyngeal pouch although the onset is usually more gradual and often extends over a period of years. The cause is obscure but is probably due to some dysfunction of the cricopharyngeus. The pouch is quite small to begin with but gradually becomes larger, extending posteriorly and usually to the left of the mid-line. Some become quite large and may even reach the thorax. The first symptoms are often a tickling sensation with an increase in mucous followed by regurgitation of food and possibly esophageal obstruction. The pouch can sometimes be emptied by external pressure.

Diagnosis is made on the basis of history and the X-ray findings. Radiographically, the pouch is filled with barium which is then seen to spill over into the esophagus. This is quite different from the pouch-like dilatation which sometimes occurs above an organic stricture.

The present treatment is surgical and the operation may be done in one or two stages. The one stage operation consists of exposure of the pouch from an anterior approach and dissection to the origin in the posterior wall of the pharynx. The procedure is greatly assisted if the tip of an esophagoscope is placed in the pouch. It can be readily palpated and can be seen when the light is on. The sac is then excised leaving about 1 cm. for closure which can be done with three layers of sutures. A drain is left in for eight days and a small pack for about forty-eight hours. The patient is fed through a tube for ten days.

The danger in this type of operation is the possibility of mediastinitis but the anatomical result is very good.

The two stage operation consists of exteriorizing the sac and closing it after a short period during which adhesions form about the neck of the sac. The danger of infection is reduced but recurrences are more likely.

A Case of Bilateral Carotid Sinus Syndrome

Dr. Richard O. Burrell

The carotid sinus reflex is one of the accessory mechanisms for the control of heart rate and peripheral arterial tension. Normally an increase in the intra-vascular pressure at the carotid bulb results in a series of impulses being sent to the vagus and cervical sympathetic chain which results in a slowing of heart rate and a decrease in blood pressure. Conversely, a decrease of pressure within the bulb results in an increase in heart rate and a rise in the peripheral arterial pressure and in the secretion of adrenalin.

In elderly individuals, particularly those with arterio-sclerosis, this reflex may become abnormally sensitive. In such cases external pressure from tight collars, from twisting of, or extending, the neck, results in a marked bradycardia or asystole and a severe drop in blood pressure. This abnormally sensitive reflex constitutes the carotid sinus syndrome. It may show its effect clinically by attacks of faintness or unconsciousness or by convulsive seizures. An abnormally insensitive carotid sinus is not described.

The case presented today is a woman aged sixty-eight who had noticed that on extension of the head she felt very faint. Clinical and electrocardiographic examination revealed that the left carotid sinus reflex was abnormally active in that slight pressure over the carotid bulb would slow her heart from a normal of seventy-five beats per minute to thirty beats per minute. Firmer pressure stopped her heart completely. A continuous electrocardiogram was shown demonstrating this effect. There were no contractions whatever for six full seconds — this was followed by a few irregular auricular contractions for a further two seconds, then the ventricles resumed their normal rhythm after a total lapse of eight seconds — the patient meanwhile feeling very faint. She could be made briefly unconscious by more continuous pressure over the left carotid bulb. At this stage the right carotid sinus reflex was normal. A peri-arterial sympathectomy of the left common, internal, and external carotid arteries in the region of the left carotid bifurcation was performed. The operation was done under deep ether anaesthesia with heavy preoperative atropinization and the bulb was infiltrated with novacaine to prevent asystole during the procedure. During her post-operative convalescence, pressure on the left bulb failed to produce the normal effect, nor was there any rise in her blood pressure.

One month later the patient returned with a recurrence of symptoms and it was noted that she had now developed a right carotid sinus syndrome. This was treated surgically in the same manner and the patient had been relieved of her symptoms and has suffered no untoward effects such as rise in blood pressure, etc., indicating that most likely there is no syndrome associated with an abnormally insensitive carotid sinus.

In dogs it has been possible to produce a transient, four month, rise in blood pressure by bilateral carotid sinus denervation, combined with periarterial sympathectomy of the aortic arch, which removes all accessory mechanism for the control of heart rate.

This case is interesting in the sudden onset of increased sensitivity in the right carotid sinus after the left sinus had been denervated, and in that bilateral denervation was uneventful. In neither side was the so-called carotid sinus nerve demonstrable, although a careful search was made. Carotid sinus syndrome is never associated with carotid body tumor.

Post-Operative Complications

M. R. Bennett, M.D.

Respiratory complications constitute the greatest single hazard to the post-operative patient. Major complications include broncho-pneumonia, lung abscess, empyema, atelectasis, embolus and pleurisy. Minor complications are cough, tracheitis, bronchitis, laryngitis, pharyngitis and hiccough. These, of course, can follow injury, illness or the use of drugs as well as surgery. From January 15, 1945, to January 15, 1946, 1,237 anaesthetics were administered by me, and of these 12.2% were followed by respiratory symptoms. This includes patients who had chronic respiratory disease before operation and also those who had the most minor symptoms. Symptoms lasted for more than four days in 7.4%, and 1.4% had major complications. In 32.8% operation had lasted over one hour. Respiratory symptoms had been present before operation in 56.2%.

Considering these complications in relation to site of operation we find that upper abdominal operations had a complication incidence of 26.9%; lower abdominal operations, 13.5%; thyroidectomies, 22%; and orthopedic operations, 7.2%.

The incidence of complications varied with the season. Complications were least frequent in February (6.7%) and June (8.6%), most frequent in October (19.6%), next in April (16%) and December (16%). The occurrence of post-opera-

tive respiratory complications depends upon two factors — the type of operation and the condition of the patient. Following abdominal operation there is a high diaphragm due to splinting from pain, meteorism, tight dressings and air under the diaphragm. This elevation of the diaphragm results in a reduced vital capacity. There is active compression of the lower lobes with diminished effectiveness of expulsive cough. The bronchi and bronchioles are narrowed and there is retention of secretions. The condition may be further aggravated by shock or by the use of drugs which depress the respiratory centre. An area of lung in which there is decreased aeration is susceptible to bronchial plugging and to invasion by organisms which may already be in the lung or which reach it by the inhalation of septic material or by septic emboli.

Unfavourable features in the patient are: (1) a history of recurrent bronchitis; (2) a history of morning cough and expectoration; (3) acute head or chest cold (with or without fever); (4) physical signs in the chest.

The following suggestions are made for the prevention of respiratory complications:

1. Postpone elective surgery if an acute infection is present. Patients should be admitted to hospital 24 hours before operation, so that a developing cold can be detected.

2. Chronic chest conditions should be treated for two or three days before operation by: Bed rest. Steam inhalations. Postural coughing. Breathing exercises. Limitation of smoking. Bronchoscopy in cases of bronchiectasis.

3. Pre-operative medication should not be excessive. In chronic chest conditions evening sedation should be omitted and operation should be done in the late afternoon.

4. Anaesthesia. This should be no deeper than necessary. Oxygen lack and CO^2 excess must be prevented. The aspiration of vomitus, mucus, etc., must be prevented. Excessive bronchial secretion should be removed by "tracheal toilet" at the end of operation.

5. Post-operative nursing care. The duties of the nurse are: 1. To prevent obstruction. 2. To prevent aspiration. 3. To prevent drug depression. 4. To carry out the "stir up" regime, especially in upper abdominal cases; (a) to encourage deep breathing once every hour; (b) to encourage effective cough once every hour; (c) to change the position of the patient every hour.

It is important that the binders be not too tight. If necessary, use CO^2 to stimulate deep breathing and cough.

6. Bronchoscopy is indicated if atelectasis occurs or if the patient is not clearing the bronchial tree effectively.

Respiratory complications are too serious to ever justify a surgeon "taking a chance." To do so is to risk the patient's life, or at the very least, to increase his post-operative discomfort, to weaken the wound and perhaps to sow the seeds of chronic pulmonary sepsis. Pre-operative caution is necessary for post-operative safety.

Discussion

Dr. Adamson suggested routine chest X-rays in all surgical patients pre-operatively. He felt that adrenalin is useful in preventing atelectasis. Dr. McEwen said that many post-operative respiratory complications are wrongly diagnosed and so-called post-operative pneumonia is really atelectasis.

Winnipeg Medical Society—Notice Board

W. F. Tisdale, *President*
Cecil W. Clark, *Vice-President*

C. K. Bleeks, *Treasurer*
R. A. MacPherson, *Secretary*

Winnipeg Medical Society

The Annual Meeting was duly held on May 17th and was quite decently attended. The proceedings opened with the reading of the Minutes of the last Annual Meeting and were duly adopted, most of the audience, as is usual, being not greatly interested in matters a year old. There was one item, however, that should have been considered a year ago which somehow had been overlooked and that was the vote of thanks to Dr. Gowron, whose fertile and artistic brain conceived and gave birth to the insigne (miscalled "crest") of our Society. Our own peculiar little ophidian thus celebrated its first birthday by enjoying the appreciation expressed for its author.

Next came the reading of the various reports. First was that of Dr. Macpherson, the Secretary, which was as follows:

Secretary's Report

The past year has been, I think, a very satisfactory one in the history of our Association. The membership is now at an all time high. During the past year there were seven Regular Meetings and one Special Meeting. The average attendance at all meetings was over 125 with a marked increase in younger members, most of whom had recently returned from the Services. Your Council met for ten meetings. The members of Council, according to the revised Constitution, were reduced this past year. This smaller Executive seemed more satisfactory and the attendance at Council Meetings was excellent.

A resume of the more important non-scientific activities are as follows:

1. The New Constitution so ably revised by Dr. F. D. McKenty and Committee was printed and distributed during the early part of this year.

2. Under the joint auspices of the Manitoba Medical Association and Winnipeg Medical Society, a subscription dinner for returned medical officers was held during April.

3. A new section on Anaesthesiology was formed during the year and promises to be a very active one.

4. The granting of complimentary memberships to men returned from the Armed Forces has been continued.

5. The overseas parcels were discontinued early in the year for obvious reason.

6. A beginning has been made in reviving the weekly curling and golf competitions, discontinued during the war.

I would like to take this opportunity to thank all those who contributed to the scientific programme during the past year. I think we all agree that the high quality of past presentation has been maintained.

Respectfully submitted,
R. A. Macpherson,
Secretary.

Following Dr. Macpherson was Dr. Bleeks, the Treasurer:

EXHIBIT "A"

BALANCE SHEET
As at 7th May, 1946

ASSETS

Cash:		
On deposit with Bank of Toronto		$ 290.52
Investments—At Cost:		
$1,000.00 Dominion of Canada Bonds, 1952—3%	$ 987.50	
$1,000.00 Dominion of Canada Bond, 1957—3%	1,000.00	
		1,987.50
Office Furniture and Equipment—Book Value		218.54
		$2,496.56
Special Library Fund:		
Cash on deposit with Bank of Toronto		302.24
		$2,798.80

LIABILITIES

Members' Fees paid in advance		$ 10.00
Surplus:		
Balance as at 9th May, 1945	$2,818.58	
Less:		
Appropriated for Library Fund	$300.00	
Overseas Expenses	176.22	
	476.22	
	$2,342.36	
Add:		
Excess of Revenue over ordinary operations	144.20	
		2,486.56
		$2,496.56
Special Library Fund Reserve:		
Account Payable—Colcleugh & Co.	$ 180.00	
Surplus:		
Excess of Revenue over Expenditure	122.24	
		302.24
		$2,798.80

EXHIBIT "B"

STATEMENTS OF REVENUE AND EXPENDITURE
For the Period Ended 7th May, 1946
GENERAL FUNDS

Revenue:		
Annual Dues:		
Active Members	$1,080.00	
Associate Members	46.00	
Payment of Arrears	26.00	
		$1,152.00
Bond Interest		60.00
Bank Interest		1.44
		$1,213.44
Expenditure:		
Salaries	$ 467.34	
Printing, Stationery and Postage	305.41	
Catering	42.88	
Telephone	27.60	
Lantern Expense	27.00	
Audit Fee	25.00	

Donations	2.00	
General Expense	21.75	
	$ 919.98	
Complimentary Dinner to returned Medical Officers—Share of Expenses	149.26	
		1,069.24
Excess of Revenue over Expenditure		$ 144.20

LIBRARY FUND

Revenue:		
Appropriated from General Surplus	$ 300.00	
Bank Interest	2.24	
		$ 302.24
Expenditure:		
Books purchased—Colcleugh & Co.		180.00
Excess of Revenue over Expenditure		$ 122.24

In Safety Deposit Box, Bank of Toronto, 394 Portage Ave.:

Dominion of Canada Bond, 3%, due Oct. 1, 1952 $1,000.00
Dominion of Canada Bond, 3%, due May 1, 1957 $1,000.00
Balance in Savings Account, Bank of Toronto, May 7, 1946 $290.52

The aforesaid Bonds and Bank Deposit have been vouched for in the Auditors' Report.

Office Equipment at 510 Medical Arts Building:

1 Steel Filing Cabinet—3 drawers.
1/2 Interest in Elliott Addressing Machine.
1/2 Interest in Speedoprint Duplicator and Equipment.
1/3 Interest in Underwood Typewriter, 14-inch Carriage, Serial No. 5732553-14.
1/3 Interest in "Copyright" Holder.

Trustees' Report

Dr. Fryer, the retiring Trustee, reported on the state of our tangible assets. This report was accepted in spite of certain glaring omissions which, I feel, are unpardonable. Among our possessions are certain cups, saucers and spoons, not, I admit, of great value but, nevertheless, ours — "Poor things but our own," so to speak. Why, Dr. Fryer, did you and your colleagues not see fit, as all your predecessors have seen fit, to number these useful appurtenances? Surely "the cup that cheers but not inebriates" plays a role of some importance in our meetings! As a member of the Society I demand to know where and in what condition are our cups, saucers and spoons!

There is, however, in this report an error which I am sure was not intended and which I should like to correct. Dr. Fryer refers to me as the donor of the gavel. I had the good fortune to be instrumental in obtaining it but it was the gift of the Royal College of Surgeons of England. The parent block of wood from which it was hewn was accompanied by a letter from the President of the College who, with his colleagues, was moved to make this highly appreciated gift through the good offices of Mr., then Surgeon Rear-Admiral Gordon Gordon-Taylor, the Senior Vice-President of the College.

Equipment in Manitoba Medical College in custody of Caretaker:

12 Wooden Chairs.
4 Wooden Trestles and 2 Wooden Table Tops for same.
1 Cupboard.
1 Gavel—This Gavel made from wood from the ruins of the Royal College of Surgeons and presented to the Winnipeg Medical Society by Dr. John C. Hossack.
1 Plaque—Honour Roll of Past Presidents (in Physiology Lecture Room of the Medical College).
Book value, $218.64

In Care of Mr. Gordon Axtell:

1 Delinescope Lantern, Model OJR, No. 3647, made by Spencer Wells Co. of Buffalo, New York, and one spare bulb for same.

The Programme Committee reported through Dr. James as follows:

Meetings of Winnipeg Medical Society Held During the Season 1945-46

Number of meetings held: Seven Regular, one Special.

October 19th, 1945

1. German War Surgery — Major Allan Klass
2. An Unusual Case of Pick's Disease — Major Herbert Meltzer
3. Hong Kong Experiences — Major John Crawford

Special Meeting—November 8th, 1945

The Food Situation and Nutrition in Great Britain Today — Sir Jack Drummond (Medical Advisor to the British Ministry of Food)

November 16th, 1945

1. What's New in Rheumatism — Dr. J. D. Adamson
2. Intussusception — Dr. C. W. Burns
3. Amoebic Dysentery — Lt.-Col. C. B. Schoemperlen

December 15th, 1945

1. Enuresis — Dr. C. B. Stewart
2. Arrangements between the C.M.A. and D.V.A. re Fee Schedule — Dr. F. G. McGuinness

January 12th, 1946

1. Pertussis — Dr. Lyon P. Strean
2. Treatment of Obesity with Dexedrine — Dr. Leonora Hawirko
3. Experience with Total Thyroidectomy — Dr. R. O. Burrell

February 15th, 1946

1. Abnormally Protruding Ears — Dr. A. C. Abbott
2. Headache — Dr. Lennox Bell
3. Present Biological Reactions by Radio Activity — Dr. A. P. McDonald

March 15th, 1946

1. Modern Anaesthetic Agents — Dr. Ralph Knight, Minneapolis
2. Relationship between the Surgeon and Anaesthetist — Dr. P. H. T. Thorlakson

April 26th, 1946

1. Cervical Intervertebral Disks with Brachial Neuritis — Dr. E. S. James
   Radiological Aspects — Dr. A. E. Childe
2. Some Case Histories of Emotional Upsets in Children — Dr. G. C. Stevens

Respectfully submitted,
Dr. E. S. James

I have not yet given up hope of getting some of these papers for publication.

The Legislative Committee had a fairly easy time of it. The question of irregulars has been answered by the Basic Sciences Act. What sometimes perplexes me is the depth to which we may sink in the matter of admitting as healers those upon whose practice we frown. It is exceedingly difficult to determine shades of black. In this affair people today are much as were the ancient Romans in their attitude towards religion, for to the people all creeds were equally true, to the philosophers all equally false and to the lawyers all equally useful. By substituting "cult" for "creed" and "physicians" for "philosophers" we bring things up to date.

Report of the Legislative Committee

The Committee had no meetings. The Chairman attended one meeting of the Committee of Fifteen of the Manitoba Medical Association. At this meeting the Minister of Health discussed the Basic Sciences Bill, which had recently passed the Legislature.

This Bill requires chiropractors, osteopaths, etc., to pass examinations set by the Senate of the University before they can be licensed to practice. The various subjects plus the number of hours study were discussed, and it was generally felt by the Committee of Fifteen that the Bill was in every way adequate.

Respectfully submitted,

Ross H. Cooper.

Dr. Edmison was well pleased with the work of the Membership Committee. My own comment upon the matter is that every one in practice should be a member. The real figure to strive for is 100 with a percentage mark behind it.

Report of the Membership Committee

The following is my report as Chairman of the Standing Membership Committee of the Winnipeg Medical Society.

The present membership of this Society now totals 365, which is probably the largest in the history of the Society. This is made up of 241 active members, 26 associate members, 18 honorary members and 80 complimentary members.

This increase in membership is largely due to the return of physicians from the armed forces as all of those returning to Winnipeg or vicinity are offered complimentary memberships for the current year and the following year. Seventy memberships of this kind have been granted during the past year and eighteen new active members have joined the Society.

Yours very truly,

H. M. Edmison, M.D.,
Chairman, Membership Committee.

Our representative on the Medical Library Committee is Dr. Ross Mitchell and he supplemented his remarks with a communication from the Librarian, Miss Monk. The facilities of the library are still not fully employed.

Report of Medical Library Representative

As the representative of the Winnipeg Medical Society on the Medical Library Committee, I beg to report as follows:

Meetings of the Medical Library Committee were held on November 4, 1945, and March 17, 1946. At each meeting many suggestions of books to be added to the Library were reviewed. Although a considerable portion was rejected, the purchase was recommended of as many books as came within the limit of the sum allotted by the University and the Rait and Freidman committee donations. It was agreed that the back numbers of foreign journals, unobtainable during the war, should be purchased as soon as possible to make the files of these journals complete. A portrait of Sir Frederick Hopkins, the father of biochemistry, was donated by Professor A. T. Cameron. The establishment of a University book bindery was recommended to the University, as the Medical Library is but one of a number of faculty libraries within the University. A further recommendation was that show cases be placed in the Board Room of the Medical College to house medical historical exhibits and rare old books.

Salary increases for the three librarians were discussed and a recommendation of substantial increases was made.

It was agreed that a microfilm viewer should be purchased.

As a newcomer to the Library Committee I was impressed with the knowledge, interest and enthusiasm of all the members.

Respectfully submitted,

Ross Mitchell.

Library Statistics, 1945-46

The following figures are a compilation from the Medical Library's statistics which are of interest to the Winnipeg Medical Society:

Additions to Library

Volumes added by purchase—Winnipeg Medical Society Grant: Books, 34; binding, 2. Total, 36 vols., or 17.22% of the total purchases.

Total additions to the Library, exclusive of unbound journals, from all sources, by purchase, gift and exchange, is 258 volumes. This is a decrease of five books, or 1.90% from last session.

The figure of books purchased, on all funds, shows a decrease of eight volumes, or 3.68%. On the Winnipeg Medical Society grant eight more books were purchased, or 28.57% over the session of 1944-45.

The total number of volumes in the Library is 15,034, which includes all journals, bound or unbound, and books.

Journals and serials received by subscriptions on University funds number 182 titles, 22 new subscriptions being added this year, 11 of them being renewals of the French and Swedish journals received before the war. The total estimated annual cost of these periodicals is $1,461.74.

Through the Winnipeg Medical Society grant the Library continues to subscribe to two loose leaf systems, originally purchased by this fund, namely, Tice's Practice of Medicine, and Davis's Gynaecology and Obstetrics.

Circulation and Reference

Circulation, Winnipeg physicians, registered brorowers, 199, or 50% of the 398 licensed city physicians. An increase in actual numbers of 44, or 2.13%.

Loans to Winnipeg physicians: Books, 888; journals, 2,246; total, 3,134 items, or 41.97% of all loans; an increase of 880, or 39.04% over 1944-45.

(The medical students borrowed 30.25% of all loans; the decrease of 18.78% is accounted for no doubt by the lack of a fourth year after August, 1945.)

Reference requests: The reference service has shown an increase again this year, with the greatest number of requests on record, the total being 209. An analysis by whom the requests were made is as follows: Winnipeg physicians (other than faculty), 97 requests, or 46.41%; faculty, 74 requests, or 35.40%; rural physicians, 20 requests, or 9.57% miscellaneous, 18 requests, or 8.61%.

♦

Dr. McKenty's report bears little relationship to the time and thought which he has given to our affairs. It merely happened that his services were not rendered to us as members of this Society and so a further account of his labours will be reported elsewhere.

Report of Committee on Economics

During the past year the economic problems affecting the Winnipeg Medical Society have been dealt with mainly by the Manitoba Medical Association. No questions affecting the Society only have been referred to the Committee on Economics.

Respectfully submitted,

F. D. McKenty.

The Eye, Ear, Nose and Throat Section was a little more active than the other sections. The only other section report was that of the Medical History Section. Towards the latter I feel as does an anxious parent when he sees the child of his hopes pale and languid. Our section needs large quantities of B Vitamins and Iron as the radio chap says. During the war years it existed but did not thrive. Now that some of our staunch enthusiasts are back we can look for definite improvement.

Eye, Ear, Nose and Throat Section Report

The Eye, Ear, Nose and Throat Section of this Society met twice during the past year.

The first meeting occurred in January, 1946, in the Board Room of the Winnipeg General Hospital. Dr. E. J. Washington presented two cases of chronic frontal sinus infection. A paper on the Extra Ocular Motor Balance was read by Dr. Walter Alexander. There followed a free and easy discussion.

The final meeting of the Section took place in the Medical Arts Club Room in May, 1946. Following a pleasant banquet a colored motion picture of the Intra Capsular Cataract Technique was presented by Dr. J. T. Cruise. The photography was directed by Mr. Wm. Doern, technician, Department of Radiology, Winnipeg General Hospital. The paper was freely discussed by practically all members of the Section. It was the unanimous opinion that Dr. Cruise had contributed singularly to the University of Manitoba Department of Ophthalmology. This picture will be shown at the Canadian Medical Meeting in Banff this summer.

Elections for the coming year were held and the new slate of officers are as follows: President, Dr. I. H. Beckman; Secretary, Dr. Walter Alexander.

Respectfully submitted,

Walter Alexander,

Secretary, Eye, Ear, Nose and Throat Section.

♦

The Nominating Committee then brought in their report and during the counting of the ballots Certificates of Life Memberships were presented to Drs. W. W. Musgrove and W. A. Gardner, who were sponsored respectively by Drs. H. D. Kitchen and O. S. Waugh.

Three other Life Memberships were awarded in absentia. The recipients were Drs. J. A. Gunn, E. A. Jones and W. Turnbull; all, unfortunately, were unable to attend.

There were two other presentations. One was the Certificate of Past President to Dr. P. H. McNulty and the other was the presentation of a case to contain the gavel. This was a gift from Dr. Goodwin.

(Continued on Page 366)

Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

The Ventriloquism of the Psyche

Every Sunday evening a very useful sermon is preached but few of the millions who listen get the "message." The "preacher" is not a parson but a clever layman with a dual sort of personality, one part being a piece of wood carved into the likeness of a boy and the other part being a man who speaks without moving his lips. Over the air the deception is complete and one ignorant of the facts might argue strenuously that the dialogue was real. But of course it is not real. We know that the sounds we hear do not issue from the wagging jaw of Charlie but from the motionless lips of Bergen. The art in which Bergen so excels derives its name from "venter" the belly and "loquor" I speak. Politely it is "ventriloquism," literally it is "belly-talking."

Now, the point is that belly-talking is not confined to the field of amusement nor to Sunday evenings. Every day every doctor has an opportunity to hear it oftener than once. Yet many, being instinctively honest and unsuspicious, do not realise that things are not always as they sound and that a clever illusion will deceive even the elect. And so, when a patient pours forth his or her tale of woe it is likely to be accepted at its face value. The belching of the pain-racked stomach, the lethargy of the liver, the stubbornness of the intestine are all accepted as evidence of disease in the viscera concerned. Sometimes, if the grumbling be very loud in the right lower quadrant, the appendix is immediately (1) suspected, (2) accused, (3) sentenced, (4) executed, only to reveal itself as completely free from any pathological intentions. If, as is likely, the symptoms still persist, suspicion next falls on the gall bladder, which, usually by other hands, is promptly extirpated. The next time symptoms recur the technique is different. Long, shiny, uncomfortable instruments disappear down the gullet and up the rectum. The various excreta are curiously examined by highly trained technicians. Barium is poured in from above and pushed in from below. Shadows are photographed and studied. Then comes the unexpected verdict, "no evidence of organic disease."

Yet the patient still complains. Whence come these recalcitrant, refractory, pertinacious symptoms? If the patient is a woman the answer seems to lie in that place of mystery — the pelvis. "Reflex from the pelvis" is the diagnosis. Man, fortunately, has no pelvis worth speaking about, but woman, alas, has a most troublesome and expensive one. It is almost impossible to find a woman who has had no pelvic symptoms. Likewise, I imagine, there is no woman whose uterus is inclined exactly at the text-book angle. Therefore, in his earnest desire to make his patient well, the surgeon now attacks the fruitful field of the pelvis. In other words—those of Sir Clifford Albutt—"She is entangled in the net of the gynecologist who finds that her uterus, like her nose, is a little on one side, or again, like that organ, is running a little, or it is as flabby as her biceps, so that unhappy viscus is impaled upon a stem, or perched upon a prop or is painted with carbolic acid every week in the year except during the long vacation when the gynecologist is grouse shooting or salmon catching or leading the fashion in the Upper Engadine." That was in 1884. Nowadays we do it differently. Nowadays the womb is Gilliamed, Baldy-Webstered, Shropshired, etc., and finally uprooted, its uselessness being complete as the ovaries and tubes have long since either been removed or rendered physiologically inactive.

With the removal of each viscus diagnosis becomes less obscure. One by one we count off the laid-to-rest suspects. The appendix, the gall bladder, the uterus, the ovaries, the tubes — how can they cause symptoms unless by remote control from the museums of various hospitals? The thorax, fortunately, guards its contents more successfully than does the soft walled abdomen. The skull debars all except those who have legitimate business therein. The lungs and the heart (sometimes when it shouldn't) escape suspicion. Only the mind is left. Thus by adding diagnosis by exclusion to diagnosis by evisceration the correct answer is reached. The symptoms were functional all the time! It was Charlie and Bergen over again, this time as tragedians. The story we heard from the patient wasn't his. It was a re-hash of what Charlie said and Charlie, of course, didn't say it; he just seemed to say it, because after all it was Psyche Bergen who thought it all up and gave it utterance.

So the half hour programme which amuses us each Sunday evening is really a sermon with a pointed message of daily application. The message is this — don't forget the ventriloquism of the psyche! When a heart, or a stomach, or a bowel or a uterus speaks with its own voice and on its own behalf it speaks clearly. Its story bears upon it the marks of truth and all the evidence goes to prove its truth. But when the psyche is at work it is no clear story we hear but a parable, a fable like those of Aesop wherein animals discourse philosophically upon highly ethical matters. But the message is none the less clear once we have penetrated its symbolism. Only we must

recognise the existence of that symbolism and be on our guard lest we be deceived by the ventriloquism of the psyche.

♦

We are always grateful to authors who, out of a sense of loyalty, submit to us contributions that would be welcomed by larger journals. It is only natural for one who has gone to trouble and expense that he should seek to lay the fruit of that labour before as large an audience as possible. Therefore, when he chooses to give it to us, we feel flattered and encouraged. The latest contributor to whom we are so indebted is Dr. A. C. Abbott, whose paper appears in this issue.

♦

Annual Meeting

The Annual Meeting of the Manitoba Medical Association will be held on September 23, 24, 25 and 26. Dr. J. D. Adamson is Chairman of the Scientific Programme Committee, and would like to hear from all those who wish to present papers on that occasion. Prospective speakers are asked to give the titles and summaries of the contents of their papers.

♦

The Annual Meeting of the Brandon and District Medical Association was held in the Prince Edward Hotel, Brandon, on May 8th, 1946, at 6:30 p.m. The President, Dr. J. R. Martin, of Neepawa, presided at both the dinner and the meeting.

The meeting was addressed by Dr. P. H. McNulty, President of the Manitoba Medical Association, on the subject of the special meeting held in Winnipeg in March, 1946.

Dr. J. M. McEachern of Winnipeg presented a paper on Coronary Heart Disease.

Dr. R. O. McDiarmid of Brandon presented a paper on Differential Diagnosis of Ocular Pain. Dr. McNulty suggested that this paper be sent to the Manitoba Medical Review for publication.

The total attendance was 26, including the two Winnipeg visitors.

Officers elected for 1946-47 are:

Honorary Presidents—Dr. W. J. Ellliott, Brandon; Dr. J. S. Poole, Neepawa.

President—Dr. R. O. McDiarmid, Brandon.

Vice-President—Dr. A. L. Paine, Ninette.

Secretary—Dr. E. J. Skafel, Brandon.

Executive—Dr. R. P. Cromarty, Brandon; Dr. J. B. Baker, Brandon; Dr. D. A. Stewart, Rivers.

Dr. H. S. Evans was elected as representative of this district on the Executive Committee of the Manitoba Medical Association, and also the representative on the Nominating Committee of the M.M.A.

D. J. Skafel,
Hon. Secretary-Treasurer.

♦

Medical History Section

(Continued from Page 362)

During the past session there was only one meeting of the Medical History Section.

During the war years our membership was low, partly because so many of our active members were in the Services and partly because those who remained at home were extraordinarily busy. However, plans are being laid for a programme of meetings during the coming session.

It is a matter of regret that the interest in medical history is so poor and, because of that, we would like to encourage the younger members of the Society to take part in our affairs.

Respectfully submitted,
J. C. Hossack,
Secretary, Medical History Section.

All the above, of course, was but the swelling prologue to the imperial theme, the moment of the evening, the Presidential Address. It was interesting and well given and justified the applause in which it concluded.

Then came the report on the voting. Our new officers are: President, Dr. Walter Tisdale; Vice-President, Dr. Cecil Clark; Secretary, Dr. R. A. Macpherson; Treasurer, Dr. C. K. Bleeks; Trustee, Dr. W. F. Abbott. The gavel was handed by Dr. Goodwin to Dr. Tisdale, and so ended the thirty-third and began the thirty-fourth session of the Winnipeg Medical Society.

♦

Chance often gives us that which we should not have presumed to ask.—Lamartine.

Personal Notes and Social News

Dr. and Mrs. F. A. Walton are happy to announce the birth of a son (George O'Donnell) on May 20th, 1946, at the Winnipeg General Hospital.

♦

Dr. Edmund Sanburn and his wife, Dr. Lillian Sanburn, have left Winnipeg for Hamilton, Ont., where they will reside in the future.

♦

Dr. and Mrs. R. Yaholnitsky are pleased to announce the birth of a daughter (Sandra Patricia Ann) on May 3rd, 1946, at St. Joseph's Hospital, Winnipeg.

♦

The sympathies of the Executive and members of this Association are extended to Dr. Roy Stewart on the recent loss of his brother, who died suddenly on May 18th.

Dr. G. L. Adamson has been elected a member of the American Psychiatric Association, according to an announcement made at the 101st annual meeting held in Chicago.

♦

Dr. and Mrs. C. S. Hershfield have left for New York City, where Dr. Hershfield will do post-graduate work.

♦

Dr. F. Elizabeth McKim, formerly of Vita, Man., has now taken up residence in Denver, Colo.

♦

Dr. Athol R. Gordon, recently demobilized from overseas service in the R.C.A.M.C., is resuming practice, with temporary offices at 505 Medical Arts Building.

Manitoba Medical Service

(Continued from Page 237, May Issue of The Review)

Since the preceding section of this article was printed in the April issue, the Dominion Provincial Council has adjourned without having reached an agreement. How does this affect Manitoba Medical Service and the various other plans throughout Canada? It seems quite unlikely that the public will permit them to be dropped. If a plan like ours has in the space of eighteen months enrolled 30,000 members, it shows a very strong body of public opinion; and if the doctors decided to discontinue the service, that group is quite capable of forming a co-operative organization, hiring as many doctors as are needed to provide a complete service, and letting the others get along as best they could. Many doctors are probably not aware that employers are subsidizing the plan to a greater or lesser degree. It improves labour-management relations. With such an experience as a guide one would have thought that a federal or provincial health service might be based on contributions from government, employer and employee.

The view is being accepted and stated that having tried out a health service for eighteen months we now know all that can be learned about the health of a large group and its requirements. We are at the moment providing treatment for two classes of people, those whose illness developed subsequent to their acquiring membership and those with ailments preceding this; in many cases the existence of disease was unknown to the patient, and for these we accept liability; others, and the number is not small, have known of the necessity for treatment, have joined, and soon after sought advice; a record is kept of these and of the first cost of treatment; quite frequently doctors tell their patients that they are sure the Manitoba Medical Service will not accept liability and advise getting in touch with the administrative office before going further. One would suppose that a year and a half would be sufficient to dispose of the pre-existing cases, but we are still paying bills for people who joined in 1944, and for ailments existing at that time. Careful screening during the last nine months has resulted in a reduction of the known pre-existing disabilities, but it can never be entirely eradicated. It must be remembered also that every month we enroll a large number of new members, so that the problem is a permanent one. I have sometimes wondered what a government faced with this situation will do. Costs of a health service are I believe based on current ailments; during the first couple of years, the costs may be from 50 to 100% higher than this, and I doubt if there will be enough doctors or money to meet all requirements.

Another benefit is that many of the public are learning of the difficulties inherent in such a plan as ours. When I receive, as I frequently do, complaints from owners or managers of a corporation with regard to decisions refusing liability for accounts, I take time to give a comprehensive explanation for our action, and also an outline of our difficulties, one of which is that 30,000 citizens and 300 doctors are looking at the same picture but from a different angle. For the next few years education of both these groups is going to require a great deal of time and energy. Doctors will have to think of the welfare of the whole community rather than the limited circle of their own patients. The citizen thinks of the doctor as a ministering and protective angel when death threatens, and far otherwise for that long period when the bill is unpaid. Recently an indignant member suggested that the serpent was an excellent emblem for the medical profession, but a devil would be even better.

Doctors find much cause for complaint, but it is little use placing their grievances before the public; they would obtain little sympathy, for rightly or wrongly people believe that the medical profession should be included in those groups who have done very well during the war.

One problem has arisen, the significance or the extent of which was not known to us when plans were being made. What limit should be placed on the amount of ancillary services, and the number of attendances that a patient can demand. We have plenty of evidence that some patients insist on them as a right claiming that they have paid for them. The gentle hint that if they are not provided might result in a change of doctors is sufficient to force the issue. I suppose it has happened to every member of an honorary staff as it has to me to be told that the patient had come in for such and such a service; usually he left the same afternoon; but you cannot do that with private patients. We do support the doctors to the extent that we have a regulation that patients cannot change doctors without authority. If such a request is made it must be in writing, and the reasons must be good. If the condition is incurable and of long standing, or if diagnosis and treatment have been agreed upon between attendant and consultant, permission is rarely given.

Another problem that we also have to face is abuse of the service by the patient. As an example in the Firefighters Service a man consulted three specialists, each of whom told him that he had

(Continued on Page 384)

Doctors Returned to Civilian Practice From Armed Forces

The following doctors have been discharged from the services and are now back in practice. Their office addresses and telephone numbers are given so that you may easily inform their old patients where they may be found:

Name	Address	Telephone No.
Adamson, Dr. Gilbert L.,	Winnipeg Clinic, Winnipeg	97 284
Adamson, Dr. J. D.,	Winnipeg General Hospital	87 681
Alexander, Dr. Walter,	214 Medical Arts Bldg., Wpg.	95 300
Allen, Dr. C. S.,	216 Panama Court, Winnipeg	41 185
Anderson, Dr. Julius,	185 Maryland St., Winnipeg	404 065
Austman, Dr. K. J.,	704 McArthur Bldg., Winnipeg	95 826
Avren, Dr. S. S.,	416 McKenzie St., Winnipeg	59 422
Baldry, Dr. Geo. S.,	616 Medical Arts Bldg., Wpg.	94 980
Barrie, Dr. J. G.,	11 Rosewarne Ave., St. Vital	204 643
Beamish, Dr. R. E.,	216 Medical Arts Bldg., Winnipeg	94 354
Bellan, Dr. S.,	400 Aberdeen Ave., Winnipeg	54 679
Bell, Dr. P. G.,	Deer Lodge Hospital, Winnipeg	62 821
Bennett, Dr. Wm. J.,	12 Newhaven Apts., Winnipeg	33 772
Benoit, Dr. C. F.,	114 Claremont Ave., Norwood	202 470
Berbrayer, Dr. Peter,	205 Boyd Bldg., Winnipeg	94 112
Berger, Dr. M.,	428 Anderson Ave., Winnipeg	
Black, Dr. Geo. M.,	10 Simcoe Apts., Winnipeg	
Bleeks, Dr. Cherry K.,	105 Medical Arts, Bldg., Wpg.	93 273
Bottomley, Dr. H. W.,	Winnipeg Clinic, Winnipeg	97 284
Boyd, Dr. Wm. J.,	1012 Ingersoll St., Winnipeg	24 427
Brotman, Dr. E. H.,	1137 Portage Ave., Winnipeg	36 500
Brown, Dr. M. M.,	508 Medical Arts Bldg., Winnipeg	93 889
Bruce, Dr. J. D.,	20 Buckingham Apts., Winnipeg	96 780
Burch, Dr. J. E.,	Winnipeg Clinic, Winnipeg	97 284
Bruser, Dr. D. M.,	58 Noble Ave., Winnipeg	
Cadham, Dr. R. G.,	City Hall, Winnipeg	849 122
Carleton, Dr. M.,	603 Boyd Bldg., Winnipeg	94 763
Chestnut, Dr. H. W.,	25 Knappen Ave., Winnipeg	
Clark, Dr. C. W.,	216 Medical Arts Bldg., Winnipeg	94 354
Cohen, Dr. R.,	600 Boyd Bldg., Winnipeg	93 275
Coke, Dr. L. R.,	238 Spence St., Winnipeg	
Collins, Dr. D. R.,	Internes' Quarters, Winnipeg General Hospital, Winnipeg	87 681
Cooper, Dr. Ross H.,	212 Medical Arts Bldg., Winnipeg	93 103
Corrigan, Dr. C. E.,	307 Waterloo St., Winnipeg	401 271
Cram, Dr. J. B.,	409 Power Bldg., Winnipeg	95 165
Croll, Dr. L. D.,	661 Broadway, Winnipeg	72 138
Daniel, Dr. E.,	Winnipeg General Hosp., Winnipeg	87 681
Davidson, Dr. Kenneth,	6 Medical Arts Bldg., Wpg.	95 683
Davidson, Dr. A. M.,	6 Medical Arts Bldg., Winnipeg	95 683
Decter, Dr. P. H.,	283 Magnus Ave., Winnipeg	59 183
Dennis, Dr. F. T.,	Deer Lodge Hospital, Winnipeg	64 861
Doupe, Dr. J.,	592 Stradbrooke Ave., Winnipeg	46 501
Downey, Dr. J. L.,	333 Bartlett Ave., Winnipeg	46 751
Easton, Dr. S.,	216-7 Curry Bldg., Winnipeg	26 477
Edwards, Dr. K. N.,	139 Girton Boulevard	Tuxedo, Man.
Elliott, Dr. M. R.,	141 Ferndale Ave., Norwood	
Elvin, Dr. Norman L.,	314 Medical Arts Bldg., Wpg.	95 317
Eshoo, Dr. H.,	Misericordia Hospital, Winnipeg	37 035
Evoy, Dr. G. H.,	264 Edmonton St., Winnipeg	94 335
Fahrni, Dr. Gordon S.,	105 Medical Arts Bldg., Wpg.	93 273
Fairfield, Dr. G. C.	Portage la Prairie, Man.	
Feldsted, Dr. E. T.,	602 Medical Arts Bldg., Winnipeg	93 996
Findlay, Dr. J. A.,	Winnipeg Gen. Hosp., Winnipeg	87 681
Flett, Dr. R. O.,	203 Medical Arts Bldg., Winnipeg	92 934
Franks, Dr. Fred,	492 Mountain Ave., Winnipeg	
Furman, Dr. M. J.,	463 Ash St., Winnipeg	403 505
Galloway, Dr. G. D.,	74 St. Mary's Rd., Norwood	
Govan, Dr. W. R.,	Abbott Clinic, 409 Power Bldg., Winnipeg	95 165
Green, Dr. P. T.,	201 Hampton St., St. James, Man.	61 622
Guest, Dr. W. C.,	151 Yale Ave., Winnipeg	
Gyde, Dr. M. C.		St. Pierre, Man.
Hall, Dr. C. W.,	1328 Pembina Highway, Fort Garry, Man.	49 498
Hamilton, Dr. Glen F.,	408 Medical Arts Bldg., Wpg.	93 846
Hart, Dr. W. J.,	Deer Lodge Hospital, Winnipeg	62 821
Hastings, Dr. D. J.,	634 Somerset Bldg., Winnipeg	98 727
Hayter, Dr. F. W.,	Deer Lodge Hospital, Winnipeg	64 861
Helgason, Dr. R. E.		Glenboro, Man.
Henneberg, Dr. C. C.,	302 Medical Arts Bldg., Wpg.	92 710
Hillsman, Dr. J. A.,	308 Medical Arts Bldg., Winnipeg	97 329
Hitesman, Dr. R. J.,	512 Medical Arts Bldg., Wpg.	94 808
Holland, Dr. T. E.,	203 Medical Arts Bldg., Winnipeg	96 948
Houston, Dr. A. B.,	937 Warsaw Ave., Winnipeg	45 925
Hudson, Dr. J. E.		Hamiota, Man.
Hunter, Dr. H. B. M.,	Deer Lodge Hospital, Winnipeg	64 861
Israels, Dr. S.,	701 Boyd Bldg., Winnipeg	97 223
Jacks, Dr. Q. D.,	410 Medical Arts Bldg., Winnipeg	95 309
Jauvoish, Dr. S.,	206 Boyd Bldg., Winnipeg	93 240
Jones, Dr. E. A.,	Ste. 5, 117 Bryce St., Winnipeg	43 283
Kasian, Dr. P.,	St. Joseph's Hospital, Winnipeg	57 211
Kiernan, Dr. M. K.,	Winnipeg Gen. Hosp., Winnipeg	87 681
Kilgour, Dr. J. M.,	Winnipeg Clinic, Winnipeg	97 284
Kippen, Dr. D. L.,	188 Home St., Winnipeg	
Klass, Dr. A. A.,	132 Matheson Ave., Winnipeg	55 022
Kobrinsky, Dr. M. T.,	968 Strathcona St., Winnipeg	71 498
Kobrinsky, Dr. Sam,	602 Medical Arts Bldg., Wpg.	95 875
Kobrinsky, Dr. Sydney,	505 Boyd Bldg., Winnipeg	93 912
Lansdown, Dr. L. P.		Pine Falls, Man.
Lazareck, Dr. T. L.,	616 Aberdeen Ave., Winnipeg	53 674
Leach, Dr. W, B.,	150 Alloway Ave., Winnipeg	71 921
Lebbetter, Dr. T. A.,	Winnipeg Clinic, Winnipeg	97 284
Leishman, Dr. J. D.,	400 Power Bldg., Winnipeg	96 234
Lerner, Dr. A. I.,	211 McIntyre Bldg., Winnipeg	
Loadman, Dr. B. E.,	Ste. 14A Pullmer Apts., Wpg.	43 601
Lotimer, Dr. L. E.,	Winnipeg Clinic, Winnipeg	97 284
Lund, Dr. P. C.,	Deer Lodge Hospital, Winnipeg	62 821
Lyons, Dr. R.,	420 Niagara St., Winnipeg	404 009
MacDonnel, Dr. J. A. K. (lady),	Winnipeg Clinic	97 284
MacKinnon, Dr. W. B.,	661 Broadway, Winnipeg	72 138
Maclean, Dr. Ian S.,	Winnipeg Clinic, Winnipeg	97 284
MacLeod, Dr. J. W.,	Winnipeg Clinic, Winnipeg	97 284
MacNeil, Dr. Robt. W.,	Children's Hospital, Winnipeg	37 271
MacNeil, Dr. Robt. W.,	Children's Hospital, Wpg.	57 031
Malkin, Dr. S.,	701 Boyd Bldg., Winnipeg	97 223
Malone, Dr. M. C.,	St. Boniface Hosp., St. Boniface	201 121
Margolese. Dr. J.,	414 Boyd Bldg., Winnipeg	24 541
Martin, Dr. J. H.,	St. Boniface Hospital, St. Boniface, Man.	201 121
Mathewson, Dr. F. A. L.,	308 Med. Arts Bldg., Wpg.	94 942
McFarlane, Dr. R. H.,	Internes' Quarters, General Hospital, Winnipeg	87 681
McFetridge, Dr. W. J. M.,	104 Arlington St., Winnipeg	
McIntyre, Dr. Donald N. C.,	303 Med. Arts Bldg., Wpg.	92 639
McKenty, Dr. J. Stewart,	514 Med. Arts Bldg., Wpg.	92 711
McKenty, Dr. Jack,	121 Girton Blvd., Tuxedo, Man.	61 777
McKenty, Dr. V. J.,	205 Boyd Bldg., Winnipeg	94 112
McLandress, Dr. Murray,	Apt. "D" Brentwood Lodge, Winnipeg	42 490
McNicol, Dr. H. L.,	Deer Lodge Hospital, Winnipeg	62 821
McPhail, Dr. Ethel M.,	90 Roslyn Road, Winnipeg	
McTavish, Dr. Geo. B.,	206 Affleck Block, Winnipeg	98 620
Medovy, Dr. Harry,	401 Boyd Bldg., Winnipeg	93 849
Miller, Dr. I.,	St. Boniface Hosp., St. Boniface	201 121
Mitchell, Dr. J. R.,	Ste. 10 Fairhaven Apts., Winnipeg	72 187
Moffat, Dr. R. G.,	340 Borebank St., Winnipeg	
Moir, Dr. J. H.,	41 Springside Ave., St. Vital, Man.	205 543
Moore, Dr. C. H.,	116 Medical Arts Bldg., Winnipeg	97 706
Myers, Dr. R. F. M.		15 Clement Block, Brandon, Man.
Natsuk, Dr. A. W.,	75 Sherbrook St., Winnipeg	36 821
Neilson, Dr. Clive,	404 Medical Arts Bldg., Winnipeg	94 041
Orchard, Dr. S. A.,	St. Boniface Hosp., St. Boniface	201 121
Perrin, Dr. M. B.,	Winnipeg Clinic, Winnipeg	97 284

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Doctors Returned to Civilian Practice from Armed Forces

(Continued from Page 375)

Pickard, Dr. E. W., 118 Lenore St., Winnipeg		
Pierce, Dr. M. M., 354 Stella Ave., Winnipeg	54 134	
Rabson, Dr. L. R., 452 Ash St., Winnipeg		
Rafuse, Dr. E. R., 320 Sherbrook St., Winnipeg		
Ramsay, Dr. F. G., 378 Borebank St., Winnipeg	402 669	
Revell, Dr. D. G., Winnipeg General Hospital, Wpg.	87 681	
Richardson, Dr. R. W., 105 Medical Arts Bldg., Wpg.	93 273	
Ridge, Dr. J. M.	Clearwater Indian Hospital, The Pas, Man.	
Riley, Dr. H. W., Winnipeg Clinic, Winnipeg	97 284	
Rose, Dr. J. E., Winnipeg Gen. Hosp., Winnipeg	87 681	
Rosenfield, Dr. V. L., 405 Avenue Bldg., Winnipeg	97 141	
Rumball, Dr. A. C., Deer Lodge Hospital, Winnipeg	62 821	
Rusen, Dr. S. D., 399 Machray Ave., Winnipeg	58 474	
Ryan, Dr. George H., Winnipeg Clinic, Winnipeg	97 284	
Sandborn, Dr. B. S. E., Grace Hospital, Winnipeg	37 271	
Scarrow, Dr. Hart G., Deer Lodge Hosp., Winnipeg	64 861	
Schoemperlen, Dr. C. B., 216 Medical Arts Bldg., Wpg.	94 354	
Smith, Dr. N. S. H., 275 Duffield St., St. James	63 224	
Smith, Dr. F. Hartley, 86 Tache Ave., Norwood, Man.	203 993	
Sommerville, Dr. A. N., 614 St. Mary's Rd., St. Vital	202 411	
Sommerville, Dr. A. N., 614 St. Mary's Rd., St. Vital		
Stephens, Dr. Gordon M., 635 Henderson Hy., Wpg.	503 963	
Stephenson, Dr. Earl, 409 Power Bldg., Winnipeg	95 165	
Stewart, Dr. D. B., 30 Ferndale Ave., Norwood, Man.	205 298	
Swartz, Dr. David, 303 Medical Arts Bldg., Winnipeg	92 639	
Swan, Dr. R. S., 215 Medical Arts Bldg., Winnipeg	94 354	
Tanner, Dr. A. R., 310 Medical Arts Bldg., Winnipeg	95 946	
Taylor, Dr. C. H., 606 Boyd Bldg., Winnipeg	98 937	
Taylor, Dr. J. R., 6B Chelsea Court, Winnipeg		
Tisdale, Dr. Paul K., Deer Lodge Hospital, Winnipeg	62 821	
Wakefield, Dr. G. E., Ste. 1, 270 Roslyn Rd., Winnipeg	44 889	
Walton, Dr. C. H. A., Winnipeg Clinic, Winnipeg	97 284	
Walton, Dr. Fred A., 3 Locarno Apts., Winnipeg	45 719	
Whelpley, Dr. E. H., 586 Ingersoll St., Winnipeg	39 061	
White, Dr. O. J., Winnipeg General Hosp., Winnipeg	87 681	
Whitehead, Dr. Robt. G. D., 91 Maryland St., Wpg.		
Willows, Dr. R. L., St. Boniface Hosp., St. Boniface	201 121	
Winram, Dr. R. G., Ste. 51 Roslyn Apts., Winnipeg		
Brokovski, Dr. T. W.	Brandon, Man.	
Brook, Dr. Joseph	Beausejour, Man.	
Bissett, Dr. E. D. R.	Pine Falls, Man.	
Brownlee, Dr. T. I.	Russell, Man.	
Corbett, Dr. Connor A.	Crystal City, Man.	
Crawford, Dr. C. S.	The Pas, Man.	
Davidson, Dr. D. A.	Cartwright, Man.	
Dick, Dr. C. J. W.	Hodgson, Man.	
Edmison, Dr. J. N., Manitoba Sanatorium	Ninette, Man.	
Fiddes, Dr. G. W. J.	Brandon, Man.	
Gendreau, Dr. L. P., Mental Hospital	Selkirk, Man.	
Goldstein, Dr. P.	Benito, Man.	
Harris, Dr. R. S.	Virden, Man.	
Howden, Dr. W. A.	Neepawa, Man.	
Hunt, Dr. D. W.	Whitemouth, Man.	
Jacobs, Dr. A. L.	The Pas, Man.	
Johannesson, Dr. T.	Gilbert Plains, Man.	
Lippmann, Dr. H. H.	Beausejour, Man.	
Luginsky, Dr. S. M.	Beausejour, Man.	
North, Dr. W. H. C.	Virden, Man.	
Ritchie, Dr. W. G.	Dauphin, Man.	
Sharpe, Dr. V. J. H.	Brandon, Man.	
Varverikos, Dr. E. D.	Selkirk, Man.	
Watkins, Dr. R. T.	Brandon, Man.	
Yaholnitsky, Dr. R.	Baldur, Man.	

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1946 Mar. 24 to Apr. 20	1946 Feb. 24 to Mar. 23	1945 Mar. 25 to Apr. 21	1945 Feb. 25 to Mar. 24	TOTALS Jan. 1 to Apr. 20,'46	TOTALS Jan. 1 to Apr. 21,'45
Anterior Poliomyelitis	....	....	2	....	1	5
Chickenpox	64	82	166	213	452	851
Diphtheria	17	15	24	33	68	129
Diphtheria Carriers	....	2	2	2	6	21
Dysentery—Amoebic	....	....	....	....	1	....
Dysentery—Bacillary	....	....	1	....	1	2
Erysipelas	7	4	8	9	23	26
Encephalitis	....	....	....	....	....	1
Influenza	7	46	20	30	138	97
Measles	54	24	41	28	130	188
Measles—German	8	1	3	1	11	11
Meningococcal Meningitis	1	4	1	2	7	8
Mumps	340	364	188	229	976	657
Ophthalmia Neonatorum	....	....	....	....	....	....
Pneumonia—Lobar	4	7	14	12	44	53
Puerperal Fever	....	....	....	....	....	....
Scarlet Fever	46	61	49	96	215	309
Septic Sore Throat	1	7	2	2	16	8
Smallpox	....	....	....	....	....	....
Tetanus	....	....	....	....	....	....
Trachoma	....	....	....	....	....	....
Tuberculosis	93	56	46	44	213	157
Typhoid Fever	1	1	5	2	4	26
Typhoid Paratyphoid	....	....	....	....	....	2
Typhoid Carriers	1	....	1	1	1	2
Undulant Fever	1	1	....	1	5	4
Whooping Cough	16	22	41	46	87	173
Gonorrhoea	178	205	133	163	755	538
Syphilis	57	53	56	45	226	208
Diarrhoea and Enteritis, under 1 yr.	13	10	1	....	43	1

DISEASES (White Cases Only)	*732,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,000 Minnesota	*641,000 North Dakota
*Approximate population.					
Anterior Poliomyelitis	....	1	1	....	....
Chickenpox	64	857	79	....	17
Diarrhoea and Enteritis, Under one year	13	....	....	....	....
Diphtheria	17	26	7	30	5
Dysentery—Amoebic	....	....	....	8	....
Dysentery—Bacillary	....	....	....	....	....
Diphtheria Carriers	....	....	7	....	....
Encephalitis—Epidemica	....	....	2	1	....
Erysipelas	7	9	....	....	1
Influenza	7	80	2	2	12
Jaundice—Infectious	....	8	....	....	2
Measles	54	4,730	40	154	39
Measles—German	8	342	1	....	....
Meningococcal Meningitis	1	7	3	10	1
Mumps	340	1,093	116	....	....
Pneumonia—Lobar	4	....	7	....	19
Scarlet Fever	46	293	23	191	41
Septic Sore Throat	1	2	....	....	....
Smallpox	....	....	....	....	....
Trachoma	....	....	....	....	1
Tuberculosis	93	242	50	7	8
Typhoid Fever	1	5	2	....	3
Typhoid Fever Carriers	1	....	....	....	....
Typhoid Paratyphoid	....	1	....	....	....
Undulant Fever	1	7	....	13	....
Whooping Cough	16	203	....	31	10
Gonorrhoea	178	591	....	....	37
Syphilis	57	430	....	....	9

DEATHS FROM COMMUNICABLE DISEASE

For the Month of March, 1946

Urban—Cancer, 42; Diphtheria, 2; Influenza, 1; Lethargic Encephalitis, 1; Pneumonia Lobar, 3; Pneumonia (other forms), 5; Syphilis, 4; Tuberculosis, 10; Hodgkin's Disease, 1; Diarrhoea and Enteritis, 2. Other deaths under 1 year, 27. Other deaths over 1 year, 174. Total 201.

Rural—Cancer, 23; Diphtheria, 1; Influenza, 5; Pneumonia (Lobar), 4; Pneumonia (other forms), 7; Syphilis, 1; Tuberculosis, 14; Septic Sore Throat, 2. Other deaths under 1 year, 17. Other deaths over 1 year, 131. Total, 148.

Indians—Puerperal Septicaemia, 1; Tuberculosis, 3; Whooping Cough, 1. Other deaths under 1 year, 1. Other deaths over 1 year 2. Total, 3.

♦

Anterior Poliomyelitis—By the time this copy of the Review reaches you the occasional sporadic case of this disease may appear. It is five years since our last epidemic (1941) so we should be aware of the possibility this year.

Mumps are still prevalent.

Diarrhoea and Enteritis under one year is a definite problem. Forty-three cases have been reported this year and quite a number of these have died. We would appreciate having every case reported so that the extent of this problem in Manitoba may be known.

Venereal Diseases show no decrease in incidence. Prompt reporting, contact tracing and adequate treatment are essentials in the effort to control these diseases.

ANTISEPSIS

In rare conditions and everyday practice

'The successful use of intrapleural lavage in a case of pyrothorax 'and bronchial fistula was described by Gilmour in 1937. The chosen 'antiseptic was Dettol which was used first in a concentration of 1 in '20 and later at full strength. At the end of each washout 20 c.c. of 'pure Dettol was left in the pleural cavity. Some of this was coughed 'up via the fistula, and some swallowed with no ill effect. The treatment 'was continued for 7 weeks, at the end of which the pleural space was 'obliterating, the fluid serous, and the patient's general condition very 'satisfactory. Recovery was uneventful.'*

** Santon Gilmour. (1937) Tubercle, vol. 19, p. 105.*

A rare case—admittedly, yet not without some bearing on problems in everyday practice.

For what can reasonably be concluded about the attributes of an antiseptic that could be so used for so long and with such a result? Obviously it must have been highly bactericidal; it must have been non-toxic, even at full strength and even on prolonged contact with the pleura and the gastro-intestinal mucous membrane; it must also have been non-irritant and

non-corrosive, for otherwise it would have increased the vulnerability of the tissues to the infection and inhibited the natural processes of healing.

And in fact the clinical experience of over 12 years, in all the contingencies of practice that call for rapid, effective and safe antisepsis, has shown that 'Dettol' does combine, in high measure, these fundamental attributes of an antiseptic for general use in medicine, surgery and obstetrics.

'DETTOL' OBSTETRIC CREAM

—a non-toxic highly bactericidal preparation sharing all the essential attributes of 'Dettol,' but with its own special place in obstetric practice.

Originally tested at Queen Charlotte's Hospital, London, in 1932, 'Dettol' Obstetric Cream is now in general use in maternity hospitals in Great Britain and throughout the Empire.

Rapidly lethal to hæmolytic streptococci

First, because of the antiseptic itself. 'Dettol' rapidly destroys—among other pathogenic organisms—the hæmolytic streptococci responsible for most puerperal infections. It was this particular quality that lead to its adoption as the routine antiseptic in London's great maternity hospital, Queen Charlotte's.

A persistent barrier to re-infection

Secondly, because of the concentration. Applied to the skin 'Dettol' 30 per cent. not only destroys the organisms present, but forms a barrier to reinfection which lasts over two hours. In grossly contaminated cases it would naturally be applied at shorter intervals; but in routine practice two-hourly applications are more than adequate.

Intimate contact with skin and mucous membranes

Thirdly, because of the vehicle. The pleasant creamy preparation remains in contact with the surface over which it is smeared. The continuity of the barrier to re-infection is thus assured.

Some clinical applications

Possessing these special attributes, 'Dettol' Obstetric Cream is used by doctors and nurses in nearly every maternity hospital of the British Empire for the sterilization of the gloved hands and for their rapid re-sterilization during the conduct of labour. It is applied as a routine to the patient's vulva, perineum and thighs, and smeared periodically over the patient's hands.

The introduction of 'Dettol' Cream into the obstetric routine at Queen Charlotte's Hospital was immediately followed by a 50 per cent. decline (by comparison with the period immediately preceding) in the incidence of puerperal infection.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DIVISION, MONTREAL

MII.C

College of Physicians and Surgeons of Manitoba

Executive Committee

Winnipeg, Man., February 28, 1946.

A meeting of the Executive Committee was held Thursday, February 28th, 1946, in the Registrar's office, 605 Medical Arts Bldg., Winnipeg.

Present: Drs. Wm. Turnbull, J. S. Poole, I. H. Beckman and W. G. Campbell.

1. Basic Science Act.

The Registrar reminded the Committee that the Council, at its meeting on October 17, 1945, had been assured that the provisions of the Act would be fully functioning on the date of its coming into force, namely, January 1st, 1946, and that no hindrance would be experienced in registering any medical graduate eligible under the Medical Act and passed by the Registration Committee. Further that the Registrar had asked the Council and also the Executive Committee of the Manitoba Medical Association to address letters to the Lieutenant-Governor, urging that the Act become properly operative not later than January 1, 1946, so that there should be no delay in obtaining registration, and that no undue hardship be inflicted on the medical profession.

What has happened:

There have been thirty-six applications forwarded from this office to the University, and today, two months after the Act came into force, we have not been privileged to register a single individual simply because not one Basic Science Certificate has been issued. All but three applications are from doctors released from the armed forces. This is certainly a very great hardship on the medical profession, and absolutely unnecessary. It was pointed out that the Basic Science Act appears to conflict with the Medical Act, and if so, either or both Acts should be properly amended.

Motion:

Moved by Dr. J. S. Poole, Seconded by Dr. I. H. Beckman: "THAT Dr. W. E. R. Coad, our representative on the Senate of the University, be asked to press the matter of these men being passed and given their certificates under the Basic Science Act." Carried.

Motion:

Moved by Dr. J. S. Poole, Seconded by Dr. I. H. Beckman: "THAT the Senate of the University of Manitoba be advised that graduates of the Manitoba Medical College, and Licentiates of the Medical College of Canada, be automatically recognized as entitled to their Basic Science Certificate." Carried.

2. Consideration of the Reappointment of Dr. Nicholas Farkas at Pilot Mound, Manitoba.

Dr. W. G. Campbell reported that he ha received a letter from Dr. F. W. Jackson, Deput Minister of Health, stating that he had receive requests from both the Town of Pilot Mound an the Rural Municipality of Louise that Dr. Farka services be extended for a further period of si months, i.e., to September 1st, 1946. Dr. Campbe stated that Dr. C. A. Corbett was going to practic at Crystal City as soon as he received his Basi Science Certificate and registration, and that h should not be debarred from this area by a unregistered doctor, especially now that the wa time privilege has expired. Crystal City is onl a few miles from Pilot Mound. Dr. D. A. David son is practicing at Cartwright, Manitoba, whic is also in that district.

Motion:

Moved by Dr. I. H. Beckman, Seconded b Dr. J. S. Poole: "THAT the Registrar be instructe to write to Dr. Nicholas Farkas, and ascertai what his intentions are. If he is willing to tak the final year in September, we will be willing t give our permission for him to remain at Pilo Mound until that time." Carried.

3. Report on Medical Appointments to the Depart ment of Veterans Affairs and the Medica Procurement and Assignment Board.

A letter from Dr. W. J. Boyd, Director Genera of Treatment Services, was read in which h asked if our Council could grant interim regis tration to officers in Department of Veteran Affairs' hospitals. In reply, the Registrar state that the Medical Act made no provision for such registration.

A letter from Dr. H. A. Procter, Canadian Medical Procurement and Assignment Board, wa read in which he inquired if permanent licenses could be granted to members of the forces wh were practicing under War Measures Acts. In reply, the Registrar stated that such member would be required to register in the regular manner or cease practice.

In both instances, the inquirers apparently were satisfied.

4. Communication from Dr. R. W. Whetter, Stein bach, Man., re: John G. Kroeker, Irregular Practitioner, Steinbach.

Dr. Campbell read the communication from Dr. Whetter which stated that a man had died in Kroeker's house while under treatment, but that the treatment had no direct bearing on the cause of death. Dr. Whetter also stated that Kroeker had several machines, and his own patent medicines for several diseases. He said that Kroeker openly admits that he keeps patients in his house, sometimes for as long as a week. Dr

Whetter wants to know "Can this man continue on in this way with no license either for the treatments he gives nor for a hospital?" Dr. Campbell stated that he had sent a copy of Dr. Whetter's letter to Dr. F. W. Jackson, Deputy Minister of Health, to find out what action could be taken under the Basic Science Act and the Hospital Act. A letter from Dr. Jackson in reply, stated he had referred the matter to the Attorney-General's Department.

The Registrar was instructed to write Dr. Whetter that the matter is now in the hands of the Attorney-General.

5. Communication from the Canadian Red Cross Society.

Dr. Campbell reported that he had received a communication from the Red Cross asking for a donation.

Motion:

Moved by Dr. I. H. Beckman, Seconded by Dr. J. S. Poole: "THAT the letter be passed on to the May meeting of the Council." Carried.

6. Consideration of the Communication from Dr. H. H. Milburn, Vancouver, B.C., to Dr. R. I. Harris, Chairman, Committee on Constitution and Bylaws, Canadian Medical Association, as laid before the Council at its last meeting.

This communication was referred by the Council to the Executive Committee for consideration. Dr. W. C. Campbell stated that all members of the Committee had received copies of this correspondence. After considerable discussion, the following motion was passed:

Motion:

Moved by Dr. W. G. Campbell, Seconded by Dr. J. S. Poole: "THAT a letter be written to Dr. P. H. McNulty, President of the Manitoba Medical Association, stating that the Committee had considered the letter, and had come to the conclusion that it would not be practical to amalgamate the Manitoba Medical Association and the College of Physicians and Surgeons of Manitoba, because of the number of Life Members." Carried.

Re: Date of Special Meeting of the Council in May

Motion:

Moved by Dr. I. H. Beckman, Seconded by Dr. J. S. Poole: "THAT the May meeting be held on Convocation Day, May 15, 1946." Carried.

Registration Committee

Winnipeg, Man., March 19, 1946.

A meeting of the Registration Committee was held Tuesday, March 19th, 1946.

Present: Drs. Wm. Turnbull and W. G. Campbell.

1. Consideration of an Application for Registration from Dr. Stuart Leonard Carey.

Dr. Carey was born in Saskatchewan, but completed his whole medical course in London, England. He is registered and in good standing with the General Medical Council of Great Britain. Dr. Carey's application is acceptable so far as his credentials are concerned.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Stuart Leonard Carey's application for registration be accepted subject to his obtaining a certificate from the University of Manitoba under the Basic Science Act." Carried.

2. Consideration of an Application for Registration from Dr. Neville Stratford Hunt Smith.

Dr. Smith is a graduate from the University of Toronto in the year 1941, and is also a licentiate of the Medical Council of Canada under date of 1941.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Neville Stratford Hunt Smith's application for registration be accepted subject to his obtaining a certificate from the University of Manitoba under the Basic Science Act." Carried.

3. Consideration of an Application for Registration from Dr. Gladstone William Jacob Fiddes.

Dr. Fiddes is a graduate from Queen's University in the year 1940, and is also a licentiate of the Medical Council of Canada the same year. The certificates are in order for acceptance for registration in Manitoba.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Gladstone William Jacob Fiddes' application for registration be accepted subject to his obtaining a certificate from the University of Manitoba under the Basic Science Act." Carried.

Registration Committee

Winnipeg, Man., April 2, 1946.

A meeting of the Registration Committee was held on Tuesday, April 2nd, 1946.

Present: Drs. Wm. Turnbull and W. G. Campbell.

The purpose of the meeting was to consider the application for registration of Dr. Elwood Reid Rafuse.

Dr. Rafuse is a B.A. of Acadia University in 1925, an M.D. of Harvard University in 1930, and is registered with the Medical Council of Canada under date of 1932. He registered to practice in Saskatchewan in 1933, and practiced in that province for a number of years. During the war he was a member of the R.C.A.M.C. He obtained a Basic Science Certificate from the University of Manitoba.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Elwood Reid Rafuse's application for registration be accepted." Carried.

Registration Committee

Winnipeg, Man., April 5, 1946.

A meeting of the Registration Committee was held on Friday, April 5th, 1946.

Present: Drs. Wm. Turnbull and W. G. Campbell.

The purpose of the meeting was to consider the application for registration of Dr. Richard Yaholnitsky.

Dr. Yaholnitsky is a graduate from the University of Alberta in 1943, and is registered with the Medical Council of Canada in the same year. He has been employed in the Army Medical Corps and is about to be discharged. He obtained a Basic Science Certificate from the University of Manitoba.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Richard Yaholnitsky's application for registration be accepted." Carried.

Registration Committee

Winnipeg, Man., April 6, 1946.

A meeting of the Registration Committee was held on Saturday, April 6th, 1946.

Present: Drs. Wm. Turnbull and W. G. Campbell.

1. Consideration of an Application for Registration from Dr. Russell Stanley Harris.

Dr. Harris is a graduate from the University of Toronto in 1940, and is registered with the Medical Council of Canada the same year. He registered in the Province of Ontario in 1940. He obtained a Basic Science Certificate from the University of Manitoba.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Russell Stanley Harris' application for registration be accepted." Carried.

2. Consideration of an Application for Registration from Dr. Paul Theodore Green.

Dr. Green is a B.A. of the University of Toronto in 1937, an M.D. of the University of Toronto in 1940, and is registered with the Medical Council of Canada in 1940. He registered with the Province of Ontario in 1940. He obtained a Basic Science Certificate from the University of Manitoba.

Motion:

Moved by Dr. Wm. Turnbull, Seconded by Dr. W. G. Campbell: "THAT Dr. Paul Theodore Green's application for registration be accepted." Carried.

Registration Committee

Winnipeg, Man., April 23, 194

A meeting of the Registration Committee wa held on Tuesday, April 23rd, 1946.

Present: Drs. Wm. Turnbull and W. G. Camp bell.

The purpose of the meeting was to conside the application for registration of Dr. Donal Alexander Stewart.

Dr. Stewart was granted a temporary licens under the War Time Amendment of the Manitob Medical Act, on January 25th, 1945. He is a grad uate from the University of Toronto in 1943, an is registered with the Medical Council of Canad in 1943. He obtained a Basic Science Certificat from the University of Manitoba.

Motion:

Moved by Dr. Wm. Turnbull, Seconded b Dr. W. G. Campbell: "THAT Dr. Donald Alex ander Stewart's application for registration b accepted." Carried.

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Manitoba Medical Service

(Continued from Page 371)

a cataract not yet ripe for operation. There wa very close co-operation between the Firefighter and the doctors. I reported that case to them pointing out that it was their problem, and their money that was being spent. They ruled that he was entitled to two opinions, and should himself pay for the third. There is no such co operation in the present service, and seeing that there are several hundred groups, I do not see how it can be accomplished. Unfortunately for us the patient gets the tale of his grievance to the management first, and much correspondence follows. In some cases we learned that the individual was a chronic grouser, and recognized as such by his fellow-workers, but in a large proportion that does not hold good. If a case is turned down soon after the enrolment of a group the feeling is left that we are not playing fair.

E. S. Moorhead, M.B.,
Medical Director

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